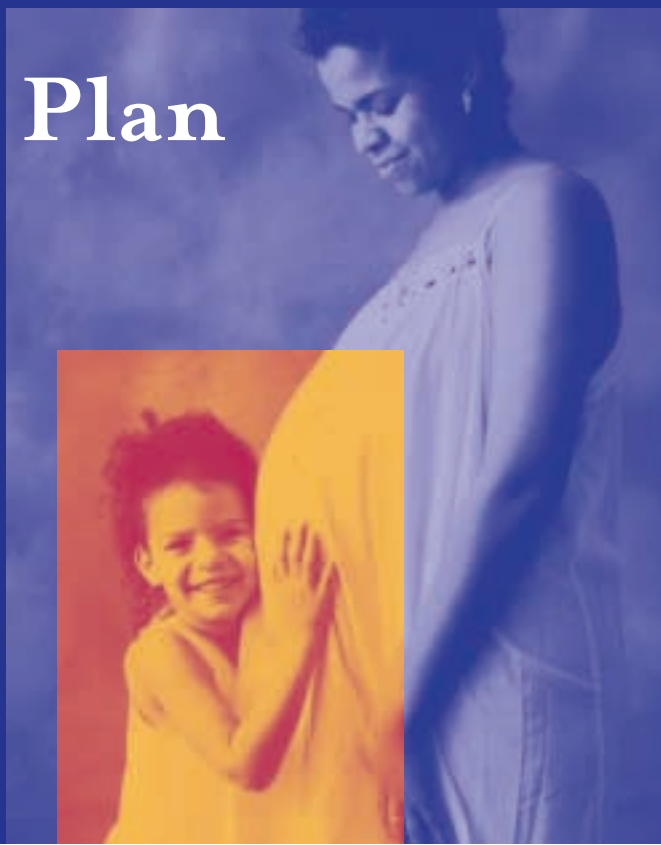
SAN FRANCISCO CHILDREN AND FAMILIES COMMISSION

From Day One

Initial Strategic Plan June 2000



"For each child that's born, a morning star rises and sings to the universe who we are."

— Ysaye Barnwell, Sweet Honey and the Rock

"If you always do what you always did, you will always get what you always got."

— Moms Mabley

Table of Contents

	Page
Acknowledgements	i
Abbreviations	ii
Executive Summary	E-1
PART I. STRATEGIC PLANNING FRAMEWORK	**1**
Introduction	1
Vision Statement of the San Francisco Children and Families Commission	1
Mission Statement of the San Francisco Children and Families Commission	1
Principles of the San Francisco Children and Families Commission	2
Framework for Strategic Planning	2
Terms Used in the Initial Strategic Plan	4
PART II. DEVELOPMENT OF THE INITIAL STRATEGIC PLAN	**7**
Organization for Development of the Initial Strategic Plan	7
Public Process	7
Legal Requirements	8
Introduction to the Strategic Plan	8
PART III. ENVIRONMENTAL SCAN	**10**
Scope of This Scan	10
The Scientific Case for Services Dedicated to Children 0-5 and their Families	10
Early Childhood Strategies and Their Effectiveness	11
Policy and Strategies for Children 0-5 and their Families and Caregivers: A San Francisco Tradition	11
PART IV. COMMUNITY ASSESSMENT	**15**
Components of This Community Assessment	15
Demographics	15
Health Status	17
Developmental Status	18
Risks	19
Strengths	21
Summary Picture of Child Health and Development	25
Gaps in Services for Children 0-5 by Focus Area	26
Community Perceptions: Input from the Civic Engagement Process	32
Integrating Services for Children 0-5 and their Families and Caregivers	34
PART V. ACCOUNTABILITY FRAMEWORK	**35**
Overview	35
PART VI. RECOMMENDATIONS AND NEXT STEPS	**37**
Recommendations	37
Next Steps	41
FIGURES AND TABLES	
Figure 1. Strategic Planning Framework: Factors Influencing Health and Development of Children 0-5 and their Families	3
Figure 2. Map of San Francisco Neighborhoods 2000	6
Table 1. Children 0-5 by San Francisco Neighborhood, 1997	16
APPENDICES	
Footnotes	A-1
References	A-6
Appendix 1. San Francisco Children and Families Commissioners	A-8
Appendix 2. Members of the Strategic Plan Advisory Committee and the Civic Engagement Advisory Committee of the San Francisco Children and Families Commission	A-9
Appendix 3. Accountability Framework 2000-2003	A-11

Acknowledgements

With gratitude and appreciation to the many individuals and organizations that provided the guidance, information, time, thoughtfulness and encouragement to develop this Initial Strategic Plan. The list would go on for pages.

Special recognition to the following:

Lucy Johns, MPH, Consultant, Health Care Planning and Policy, San Francisco

Andrea Youngdahl, Executive Director, San Francisco Children and Families Commission

Amy Ackerman, Deputy City Attorney, San Francisco

Krystal Robinson, Civic Engagement Project Coordinator, San Francisco

Carol Stevenson, Director, San Francisco Starting Points Initiative

The Proposition 10 Technical Assistance Center at the California Center for Health Improvement, Sacramento

JPD Communications, Graphic Design

The San Francisco Children and Families Commissioners (Appendix 1)

Members of the Strategic Plan Advisory Council and faithful members of the public who participated on a regular basis (Appendix 2)

Members of the Civic Engagement Committee and other organizations and individuals who helped the Civic Engagement Project come to life (Appendix 2)

The San Francisco Starting Points Initiative staff and members of the Early Childhood Interagency Coordinating Council

Staff at the San Francisco Department of Children, Youth and Their Families

The Translators, Child Care Providers, Organizations, and Food Folks who provided the essentials for the Community Conversations

The Families and Caregivers of San Francisco's Young Children – those who are born and those who are yet to be born

And to the Children…

Abbreviations

AAP	American Academy of Pediatrics
AIM	Access for Infants and Mothers
CARES	Compensation and Retention Encourages Stability Initiative
CCPAC	Child Care Planning and Advisory Council
CCS	California Children's Services
CHDP	Child Health and Disability Prevention
CMHB	Community Mental Health Branch (of DPH)
CPD	Child Development Program (of SFUSD)
CSP	Children's Services Plan (of DCYF)
DCYF	Department of Children, Youth and Their Families
DHS	Department of Human Services
DPH	Department of Public Health
Dx	diagnosis
ECIC	Early Childhood Interagency Council
E-code	etiology code
FRC	Family Resource Center
HMO	health maintenance organization
HRIIC	High Risk Infant Interagency Council
LGBT	lesbian, gay, bi-sexual, transgender
R&R	Resource and Referral agency
SF	San Francisco
SFUSD	San Francisco Unified School District
State Commission	California Children and Families Commission
STD	sexually transmitted disease
UCSF	University of California-San Francisco
WIC	Women and Infant Care

Executive Summary

Executive Summary

"Wouldn't you like to believe that we and our leaders would make sure...that our personal, social, business and public policies and practices made it easier rather than harder for parents to support their families and meet their children's needs?"
—Marian Wright Edelman, The Children's Defense Fund

"We have to make the investment in our children now. It's the economically – and morally – sound choice."
—Rob Reiner, California Children and Families Commission

INTRODUCTION

The Children and Families Act of 1998 (Proposition 10) provides funds to invest in the health and development of children 0-5 and their families. The funds come from a new tax on tobacco products. Each California county receives a portion of these funds to be invested according to a strategic plan approved by a Children and Families Commission in that county. A statewide Children and Families Commission assists the counties with their planning and also invests funds in statewide activities to benefit children 0-5 and their families.

The San Francisco Children and Families Commission, convened in May 1999, has developed its Initial Strategic Plan, FROM DAY ONE, out of its conviction that what we do to support families and young children in their early years matters to all of us. We know now from research what parents and caregivers have always known – that the ways we begin our lives lay the foundation for our future.

Over the past several months, the Commission and its partners have worked together to decide how best to use the new resources available through Proposition 10 to create meaningful, flexible and quality opportunities for San Francisco children, prenatal to five years, and their families. The Commission has been inspired in this effort by the following vision:

All San Francisco children will thrive in supportive, nurturing, and loving families and communities. They will be born free of preventable health and developmental problems and their first five years will be safe, supported, healthy, and stimulating. They will start school eager to continue to learn and grow into confident and contributing adults who nurture their families and participate in their communities and society.

The following mission statement expresses the San Francisco Children and Families Commission's essential purpose, a first step to achieving the vision:

The mission of the San Francisco Children and Families Commission is to instill an enduring obligation in San Francisco residents and government to ensure the opportunity for optimal health and development for every child born and raised in this county. This means a commitment to support young children and their families from prenatal to five years of age through abundant opportunities to be

healthy, learn, and grow. Children will reach their full potential. Families will be empowered and engaged civic partners in the work of the Commission.

The San Francisco Children and Families Commission also holds a number of strong beliefs, commitments and values that infuses its work. These are embodied as a set of principles to ensure that activities and funded strategies will be:

- *family-centered and easily accessible;*
- *designed for the "whole child," including physical, cognitive, emotional, and broad community components;*
- *built on the strengths of families and communities;*
- *reflective of the changing needs of families and communities;*
- *culturally and linguistically appropriate and reflective of San Francisco's diversity;*
- *universally available but tailored to differing needs;*
- *respectful of parent/caregiver and provider relationships;*
- *inclusive of family participation at all levels;*
- *oriented to prevention and early intervention;*
- *linked between systems and settings;*
- *consistent with continuing input from the civic engagement process;*
- *inclusive of community-based education and outreach;*
- *sustainable and maximizing use of public and private funds and existing resources.*

Based on this vision, mission and these principles, the San Francisco Children and Families Commission has conducted a planning effort involving contributions from many individuals and organizations. These include community participation through its Civic Engagement Project, community input through Commission meetings and special public hearings, careful and thorough work by a Strategic Plan Advisory Committee, and linkages with existing and previous planning and activities in San Francisco to support San Francisco children 0-5 and their families. From this effort, a set of recommendations has been developed that embody the Commission's commitment to an integrated, flexible, innovative, community-based and family-friendly approach to making Proposition 10 come alive in San Francisco.

RECOMMENDATIONS

Opportunities for Building Collaboration

From Day One, prenatal to five years, young children and their families should thrive and have abundant opportunities to be healthy, grow and learn. To accomplish this vision, collaboration must become more than a word – it must become what, at its heart, it is – no more and no less than creating community in its deepest sense. It is the Commission's intent that strategies funded through Proposition 10 will integrate and coordinate services, supports and activities so that families, providers, agencies and communities may come together to provide great beginnings for San Francisco's children. The Commission believes that through weaving together existing services, funding new and innovative strategies, developing policy and promoting system change, San Francisco will approach the real collaboration that will make a difference for families and their young children.

To do this, the Commission has determined that its work will be built upon the informal and formal platforms that reflect the lives of children 0-5 and their families and caregivers. These platforms are not a program or a service; rather they are the places and opportunities to imbue the philosophy, values, and capabilities that will result in achieving a collaborative approach to sup-

porting San Francisco's young children 0-5 and their families and addressing whatever is most meaningful for them. These places and opportunities include:

- **Where Parents Prepare for Birth or a New Child:** with relatives and friends, at health care settings, with medical providers, at private and public adoption agencies, at birth classes, at pre-adoption classes, in mothers groups, through breastfeeding and lactation support
- **Where Children are Born:** in the hospital, at home
- **Where Children and Families Live:** at home, with relatives, with friends, at shelters, in foster care, in institutions, in the hospital, on the streets
- **Where Children Play and Learn:** with family and friends, at child care and preschool, in playgroups, at playgrounds and parks, in libraries and schools, in neighborhoods
- **Where Families Go:** to friends and relatives, to the store and the laundromat, to places of faith and worship, to coffee shops and restaurants, to family resource centers, to social clubs and community centers, to parks, to museums and zoos, to the movies
- **Where Children and Families Get Services:** the health care system, the legal system, at immigrant services, at housing and tenant services, through public and community-based agencies
- **Where Families Receive Information and Support:** from relatives and friends, from the media (television, radio, small and large newspapers, signs on Muni and BART), from pediatricians and other medical professionals, from midwives, from the faith community, at parent support and education forums, from early childhood and family support service providers

The following recommendations of the San Francisco Children and Families Commission for its initial strategic plan will be provided through these platforms. The Commission, through its staff and other activities, will support the development of collaborative efforts based on these platforms, with the overall goal of improving access to the needed information, support and services that will result in children flourishing in supportive, nurturing and loving families and communities.

Recommendations by Focus Areas

The following recommendations reflect the thoughtful and committed work of everyone involved with planning for the implementation of Proposition 10 in San Francisco. To the extent possible in this first year of the Commission's work, the recommendations voice the concerns and interests of the families of young children in San Francisco. The recommendations are organized by the three major focus areas of Proposition 10, Early Care and Education (Child Development), Child (and Family) Health, and Family Support and Parent Education. In addition, a fourth focus area, Children and Families Needing Enhanced Services, has been added. Possible evaluation indicators have been developed in each of the four focus areas (see Appendix 3), and will be refined during the next steps to implement the Strategic Plan. This work will take place in conjunction with the development of a comprehensive evaluation process.

Focus Area: Early Care and Education (Child Development)

STRATEGIC OUTCOMES

- A full array of parent-friendly child care options is available where people live and work
- The child care sector has an adequate, stable and well-trained work force to promote high quality of care

- Child care workers have access to high quality training, conveniently located, in multiple languages
- All child care programs meet high quality standards, including operation in safe and healthy environments for children

SHORT-TERM OBJECTIVES

- Improve child care provider compensation and quality
- Increase capacity for infant/toddler child care and respite child care

STRATEGIES/INVESTMENT OPPORTUNITIES

- Create, support, expand, and monitor strategies to increase compensation and benefits for child care providers, including the Compensation and Retention Encourages Stability (CARES) Initiative.
- Increase the number of infant/toddler child care spaces through operational support for existing and new child care centers and family child care providers. Tie this support to efforts to improve quality.
- Support coordinated, high quality training and quality improvement, including incentives and credits, for licensed and license-exempt child care providers. Foster skills that help prepare children for continued learning in school.
- Create a subsidy fund to establish and pay for respite care, including care for children with special health care needs and their siblings, children who are mildly ill, and emergency back-up.
- Build capacity through technical and peer support for child care providers and parents who use child care in order to strengthen the field and develop additional strategies to address the infrastructure issues in the field, such as wages and benefits, capacity, affordability, accessibility and quality.

Focus Area: Child (and Family) Health

STRATEGIC OUTCOMES

- Every child has a medical home and receives optimal and family-centered nutrition, well-baby/child health care including dental care, mental health, intellectual stimulation, emotional support and early identification and intervention of any health or developmental problems
- Disparities in child health outcomes by race/ethnicity are explicitly addressed and decreased
- Every child born to a San Francisco resident is free of preventable health and developmental problems

SHORT-TERM OBJECTIVES

- Increase coordinated, integrated and community-based strategies designed to address family-centered child health needs
- Design and tailor strategies to address and decrease health outcome disparities

STRATEGIES/INVESTMENT OPPORTUNITIES

- Expand, to address the unmet need, mental health consultation to staff at child care centers, family child care and license-exempt child care providers, staff at family resource centers, shelters, treatment programs, etc. Consultation may also include clinical services. Provide linkages with child health clinics and the medical home.
- Develop a pilot to coordinate health, mental, dental and social services, with an emphasis on early identification, assessment and intervention and addressing coordination and follow-along at the point of transition into kindergarten. Models may include neighborhood-based multi-agency teams, integrated information sharing, and ways to enhance kindergarten readiness.

- Develop a pilot to enrich pediatric care through family-centered, multi-disciplinary primary care teams with particular emphasis on expanding opportunities for developmental screening, assessment and services. Create linkages with child care and family resource and support settings.
- Support the development and integration of anti-tobacco policies and community-based tobacco cessation programs for pregnant and parenting women and their partners and coordinate programs with existing early childhood and family support services and programs.

Focus Area: Family Support and Parent Education

STRATEGIC OUTCOMES

- Families have the opportunity for support, education and information that nurtures and encourages parenting conducive to the optimal health and development of children
- Parents, caregivers and community members have opportunities to create parent-friendly, family and child-centered, culturally and linguistically appropriate spaces and activities that build community, expand knowledge, increase resiliency and deepen wisdom and joy

SHORT-TERM OBJECTIVES

- Improve easy access to real information
- Increase and coordinate a wide range of family support and parent education opportunities that reflect the needs of diverse families and communities

STRATEGIES/INVESTMENT OPPORTUNITIES

- Support family resource centers as a point of triage to provide linked, standardized, and centralized services and supports tailored to the needs of diverse families. Services and supports may include peer groups and supports; parent education; information and referral; training and education for families and providers; and home visiting strategies.
- Develop and link a variety of peer-based parent/caregiver support groups, community activities and educational opportunities that are reflective of San Francisco's diversity and provided in a variety of settings
- Promote parent-initiated/community-based support strategies that are designed, organized and implemented by parents/caregivers to meet their own identified needs.
- Explore ways to centralize or coordinate existing sources of information and referral and to ensure the provision of reliable information.
- Develop a multi-lingual, multi-cultural information campaign to educate parents about children's health and development and resources for children 0-5 and their families.
- Coordinate current pre- and post-natal home visiting programs, and develop home visiting pilot(s) for outreach to families. Link home visiting efforts to the child's medical home and other services and supports for the child and family.

Focus Area: Children and Families Needing Enhanced Services

STRATEGIC OUTCOMES

- Children and families needing enhanced services will be supported from the prenatal period through birth to age five with coordinated, family-centered services and supports tailored to overcome risks and to enhance child, parental, family and environmental strengths and resiliency

SHORT-TERM OBJECTIVES

- Increase coordinated services and supports for children and their families who are homeless
- Support interagency, parent-professional collaboration to support and serve children with special health care needs and their families

STRATEGIES/INVESTMENT OPPORTUNITIES

Children and their Families who are Homeless:

- Provide comprehensive health and mental health services in shelters and where families and children are, including domestic violence shelters and treatment programs and link child care centers to shelters for provision of needed child care.
- Provide coordinated, centralized, and collaborative referral and access to crisis mental health, housing, jobs and other resources, including centralized access to shelters for pregnant women and families.

Children with Special Health Care Needs and their Families:

- Provide interagency training, development of coordination and collaboration, and other activities to increase the early identification of and effective service delivery to children with special health care needs and their families. .

Activities to Promote More Effective Early Childhood Policies and Practices

In addition to the above recommended investment strategies, the San Francisco Children and Families Commission will allocate resources, not necessarily financial, to promote change in local, state and federal policy and practice which would contribute to optimizing the health and development of children 0-5 and their families. Such issues include but are not limited to:

- Compensation to child care providers, especially providers of infant care, that reflects the cost of doing business in San Francisco (also recommended as a funded strategy).
- Transportation options that accommodate working parents, parents with more than one child, and other family situations that call for flexible transportation.
- Universal health care coverage for children 0-5 and their families, including family planning and prenatal care and services for children with special health and developmental needs.
- Universal child care for all families who want the service, regardless of income.
- Increased capacity for developmental assessments and universal, comprehensive and periodic screening through Child Health and Disability Prevention (CHDP).
- Linkages among San Francisco city/county departments serving children and their families to ensure parent education in preventable diseases and conditions and action by appropriate agencies when environmental risks can be reduced.
- Insurance coverage of pre- and post-natal home visiting
- Safe, accessible and beautiful neighborhoods and child care facilities, including playgrounds.
- Affordable and transitional housing, for example through a master lease apartment program.
- Substance abuse treatment programs that accommodate parents and children.
- Employer support and promotion of family-friendly employee policies and practices and business support for the work of the Commission
- Inter-agency and multi-disciplinary collaboration, training, integrated funding streams, uniform and linked eligibility criteria and procedures, and coordinated data systems.

Framework for Strategic Planning

To organize the planning to develop the above recommendations, the San Francisco Children and Families Commission used a framework for strategic planning based on the requirements of the legislation and years of research into the factors that inhibit or optimize health and development of young children and their families. The framework suggests:

- that the health and development of children 0-5 and their families move along a continuum from poor to optimal;
- that a child's location on the continuum reflects continual interaction of risks (negative factors) and strengths (positive factors);
- that a child's location on the continuum can be changed by services and supports intended to counter the risks and to enhance the strengths; and,
- that regardless of focus area, services and supports should be integrated so as to provide what is most meaningful to a family, not overwhelm the family or duplicate resources used.

FINDINGS

What Research Tells Us

Research over the past twenty years proves the newborn baby's brain is more active than most people thought. Infants interact with their environment before birth and from that moment on. Recent research suggests that infant experience sets hormonal response levels for life and that certain factors in early life, primarily nutrition, explain some aspects of health and development throughout life.

The San Francisco Approach

Numerous local policies, government agencies, and private organizations in San Francisco have promoted the health and development of young children and their families for many years. This history implies "a San Francisco approach" to planning and delivery of services for children and their families which is characterized by:

- a holistic view of child health and development as the product of multiple, complex factors;
- comprehensive direct services for children and families;
- solicitation of public participation in development of policy;
- inter-disciplinary and inter-agency collaboration;
- cultivation of strong relationships between government and private agencies.

Who the Children and Families Are

San Francisco is home to 53,932 children age 0-5 (1998), an age group that grew by 51 percent since 1990. The racial/ethnic breakdown of this child population is:

Asian/Pacific Islander (PI):	19,450	36%
White:	15,672	29
Latino:	12,307	23
African-American:	6,389	12
Native American:	114	<1.

Five San Francisco neighborhoods have 3,000 or more children 0-5: Inner Mission/Bernal Heights (5,724), Outer-Mission/Ingleside-Excelsior (5,265), Visitacion Valley (3,530), Sunset (3,490), and Bayview-Hunter's Point (3,066). An estimated 57 percent of children 0-5 - around 31,000 - live in households with two working parents or one employed single parent. An estimated 22 percent of children 0-5, about 12,000 children, live in poverty in San Francisco. Many families with very young children are homeless: 2,800 such families need emergency or transitional housing in San Francisco every day. Children 0-5 comprised over 50 percent of first-time placements in foster care, for which the predominant reasons were neglect (76 percent) and abuse (19 percent).

Health and Developmental Status

With only about 8,000 births per year, San Francisco birth and fertility rates are far below the statewide rates. Rates of self-reported substance abuse during pregnancy show smoking leads with 6.6 percent but all are below statewide averages. Five hundred births per year are to teens, of whom 33 percent (199) are under 18 and 75 percent are Latina and African American. In 1998, 86% of mothers initiated early prenatal care, with lower rates among African American, Filipina and Latina mothers. Death rates among the very young are low but racial-ethnic disparities are prevalent and all exceed the Healthy People 2010 national goals. Routinely monitored illness among the very young is generally low but assessment and utilization data for non-reportable morbidity like asthma, mental problems, and untreated dental caries show racial-ethnic disparities and suggest significant unmet needs. Prevalence data for developmental status and special needs among children 0-5 are not available, but utilization data indicate that hundreds have developmental delays and other disabilities.

Risks and Strengths

Risks to child health and development of concern in San Francisco include: low levels of education and literacy among parents; poverty; racism; housing; cost of living; violence; substance abuse; and environmental hazards. Strengths in families and in communities that enable the very young to flourish in San Francisco include: family and friends, parental health, education, and literacy; income; jobs; housing; nutrition; health insurance; child care; family support; and effective communities.

Needs and Gaps in the Focus Areas

1. Gaps in Child Care: Shortage of about 1,500 infant care spaces; no survey of parental preferences; inadequate capacity for emergency backup, care of mildly ill, care after-hours and summers, care of children with special needs, respite care; shortage of subsidies for poor but working parents; lack of centralized eligibility and placement system; factors (such as low wages, no benefits, and lack of training in child health and development) that can undermine quality despite some ameliorative programs (CARES program, Child Care Facilities Fund, High Quality Child Care Initiative).
2. Gaps in Early Intervention: Lack of family-centered, comprehensive, multi-disciplinary early and periodic assessment to identify developmental and health issues.
3. Gaps in Services for Children with Special Needs: Above all, the lack of integration and coordination among agencies, among sectors (child health, child development, family support, schools), between parents and providers.
4. Gaps in Child Health: No information at all concerning the health of parents and caregivers, a child's most significant defense against the risks of early life; rates of prenatal care and immunization that are improving but still below Healthy People 2010 goals; no systematic approach to prevention of violence (to be addressed with a national Safe Start grant in FY2000-2001); high barriers to access for dental services; low use of and problems accessing mental health services compared to estimated prevalence; unknown number of uninsured despite MediCal and Healthy Families coverage options; low rates and limited scope of CHDP screening; lack of employer-based health insurance for parents and dependents; limited capacity for home visiting; inadequate attention to lead hazards in old housing stock.
5. Needs and gaps revealed by parents in focus groups convened through the Community Engagement Project: better information (single number; a real listener; specific advice); more

accessible child care; need for parent education and support; and issues regarding the affordability of San Francisco.

6. Needs and gaps discussed in the community conversations convened through the Community Engagement Project: concern about child care, including availability – especially for infant/toddler care and flexible care, lack of subsidies or sliding fees for working parents, quality and ongoing provider training and education, support for provider compensation; interest in community-based parent support and education, including the need for real information; need for increased mental health prevention services and training and consultation for providers; dental health education and increased access to low-cost dental care; ways to address the stress of working parents who would like more quality time with their children; the growing concern of low and middle income working families who are finding it increasingly difficult to afford living in San Francisco; and the desire to make San Francisco a more child and family friendly city.

The San Francisco Children and Families Commission's Response

The Commission has developed an "Accountability Framework" to clarify what potential investments are intended to accomplish and how SFCFC will know whether its intentions are being met. The components of the Accountability Framework are: Target Populations; Strategic Outcomes; Short-term Objectives; Strategies/Investment Opportunities; and Evaluation Indicators.

The Accountability Framework presents: five Target Populations; 20 Strategic Outcomes; 80 Short-term Objectives; dozens of Strategies/Investment Opportunities; and a selection of Evaluation Indicators. The final recommendations chosen from this Accountability Framework reflect the thoughtful and committed work of the Commission, and its partners, in listening to and addressing the voices and concerns of the parents and caregivers of San Francisco's young children.

The Commission has identified next steps to begin implementation of the Strategic Plan. These steps are based on recommendations reviewed and approved by the Commission, including:

1. Development of the Allocation Process, including an RFP process and budget
2. Development of an Evaluation Process, including refinement of the evaluation indicators
3. Continuing the Civic Engagement Process
4. Ongoing activities building upon the initial work of the Strategic Plan Advisory Committee
5. Implementing Staffing and Administrative Structure Recommendations as approved by the Commission

This Initial Strategic Plan is the first step in an ongoing process to create greater opportunity for children 0-5 and their families. The Plan includes the word "Initial" in its title to emphasize that, even in its final form as of June 2000, it is only the first of many strategic plans. As new concerns emerge and conditions in San Francisco change for young children and their families, the so will the San Francisco Children and Families Commission's Strategic Plan.

The Commission will continue to analyze and develop strategic ways to address the issues raised in this plan. The Commission acknowledges that it will not be able to accomplish all of its recommended strategic outcomes in the first year. The plan will be further developed and implemented over time, and will be flexible and responsive to the emerging needs of San Francisco families and communities.

Strategic Plan

PART I. STRATEGIC PLANNING FRAMEWORK

Introduction

One hundred years ago, a third or more of San Francisco children from birth to five years old routinely died every year, mostly from infectious diseases like pneumonia and tuberculosis and diarrhea. Today, while greater numbers of children survive their first birthday, it is social and environmental hazards that often threaten the well-being of children 0-5 and their families. The primary focus of current public policy, then, is to ensure that young children will be as healthy and well-developed, mentally and socially, as each one can be.

The Children and Families Act of 1998 (Proposition 10), a ballot measure approved by the people of California, provides funds to invest in the health and development of children 0-5 and their families. The funds are collected by the state from a new tax on tobacco products. Each California county receives a portion of these funds related to the county's birthrate. The funds are to be allocated according to a strategic plan approved by that county's Children and Families Commission. A statewide Children and Families Commission (State Commission) assists the counties with planning and also invests in statewide activities to benefit children 0-5 and their families.

The San Francisco Children and Families Commission developed this Initial Strategic Plan (Strategic Plan) to guide the investment of funds to improve the health and development of San Francisco's youngest residents. The Strategic Plan incorporates substantial public input from an organized Civic Engagement Project (see Part II) and from customary San Francisco proceedings for public documents. Approval of the Initial Strategic Plan by The San Francisco Children and Families Commission means that funds allocated to San Francisco can be spent according to procedures to be specified by the San Francisco Children and Families Commission.

The Strategic Plan includes the word "Initial" in its title to emphasize that this Strategic Plan, even in its final form as of June 2000, is only the first of many strategic plans to be developed by the San Francisco Children and Families Commission. As conditions in San Francisco change for young children and their families, so will the San Francisco Children and Families Commission's Strategic Plan.

Vision Statement of the San Francisco Children and Families Commission

Strategic planning for children 0-5 and their families by the San Francisco Children and Families Commission will be inspired by the following vision statement:

All San Francisco children will thrive in supportive, nurturing, and loving families and communities. They will be born free of preventable health and developmental problems and their first five years will be safe, supported, healthy, and stimulating. They will start school eager to continue to learn and grow into confident and contributing adults who nurture their families and participate in their communities and society.

Mission Statement of the San Francisco Children and Families Commission

The following mission statement expresses the San Francisco Children and Families Commission's essential purpose, a first step to achieving the vision:

The mission of the San Francisco Children and Families Commission is to instill an enduring obligation in San Francisco residents and government to ensure the opportunity for optimal health and development for every child born and raised in this county. This means a commitment to support young children and their families from prenatal to five years of age through abundant opportunities to be healthy, learn, and grow. Children will reach their full potential. Families will be empowered and engaged civic partners in the work of the Commission.

Principles of the San Francisco Children and Families Commission

The San Francisco Children and Families Commission holds a number of strong beliefs, commitments and values that will infuse its work. These are embodied as a set of principles to ensure that activities and funded strategies will be:

- *family-centered and easily accessible;*
- *designed for the "whole child," including physical, cognitive, emotional, and broad community components;*
- *built on the strengths of families and communities;*
- *reflective of the changing needs of families and communities;*
- *culturally and linguistically appropriate and reflective of San Francisco's diversity;*
- *universally available but tailored to differing needs;*
- *respectful of parent/caregiver and provider relationships;*
- *inclusive of family participation at all levels;*
- *oriented to prevention and early intervention;*
- *linked between systems and settings;*
- *consistent with continuing input from the civic engagement process;*
- *inclusive of community-based education and outreach;*
- *sustainable and maximizing use of public and private funds and existing resources.*

Framework for Strategic Planning

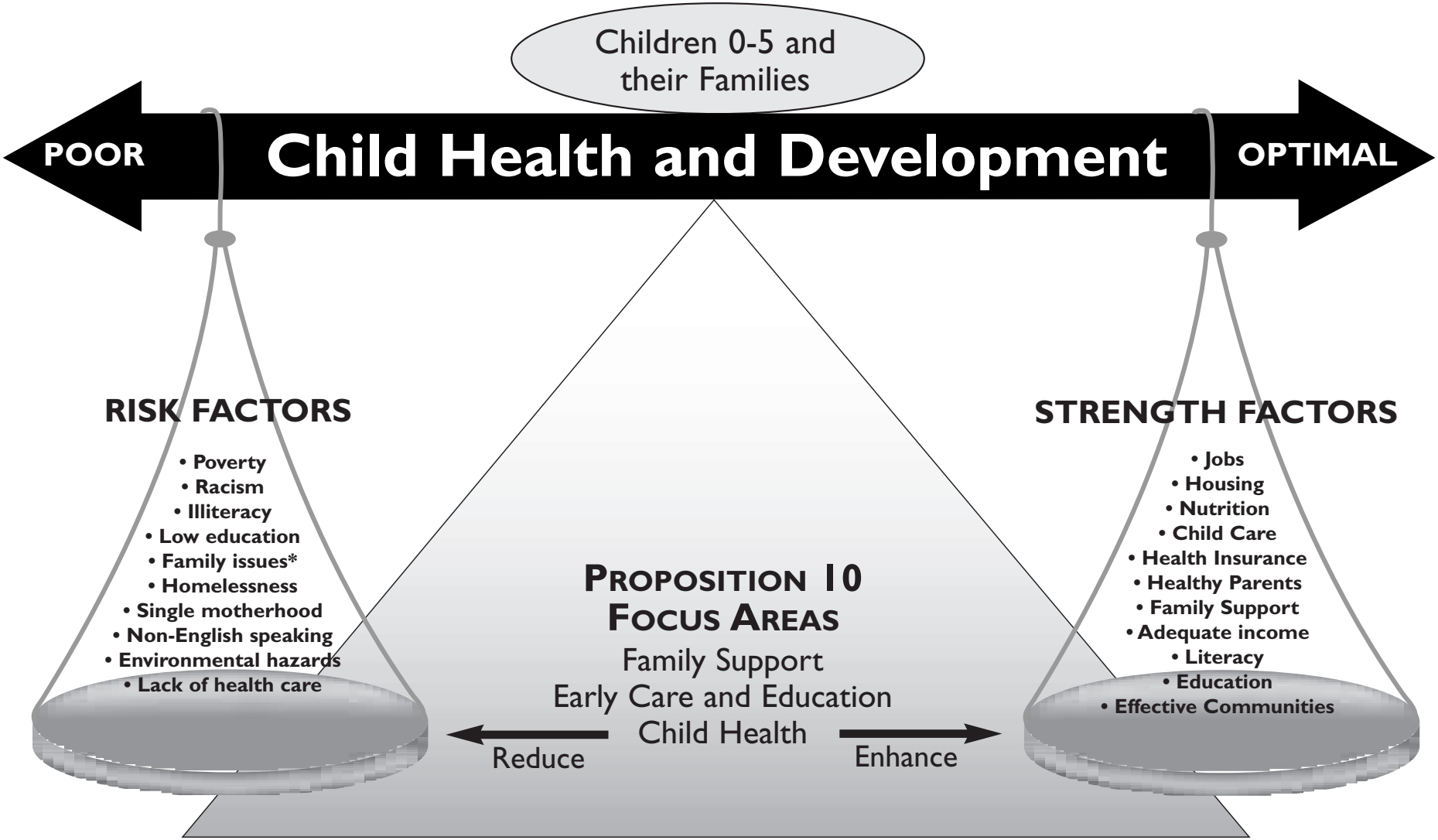
The Act presents a new opportunity for the State and the county Children and Families Commissions. It requires strategic planning and investment in a choice of effective approaches that historically have been developed, funded and promoted by distinct - occasionally competitive - disciplines, government departments, and private organizations. It implies a need for unprecedented integration of: early care and education, child health and development, and family support; professions and programs; evaluation methodologies. It envisions services and supports that are "consumer-oriented and easily accessible." By doing all this, it imposes a special burden on the Commissions to approach their tasks as comprehensively and collaboratively as possible.

One way to begin to tackle the Act's complexities is to organize them into a "strategic planning framework." The framework provides a picture of key elements addressed by the Act: a population whose health and development is influenced by risks and strengths that can be mitigated or encouraged by public policy and investment of public funds. The framework to be used by the San Francisco Children and Families Commission is shown in Figure 1. It suggests:

- that the health and development of children 0-5 and their families move along a continuum from poor to optimal;

Figure 1. Strategic Planning Framework:

Factors Influencing Health and Development of Children 0-5 and Their Families



* Issues include: violence, substance abuse, neglect, depression, abuse, and isolation.

Lucy Johns 2000

- that a child's location on the continuum reflects continual interaction of risks (negative factors) and strengths (positive factors);
- that a child's location on the continuum can be changed by services and supports that are intended to counter the risks and enhance the strengths; and,
- that regardless of focus area, services and supports should be integrated so as to provide what is most meaningful to a family, not overwhelm the family or duplicate resources used.

The strategic planning framework implies a large range of risks and strengths to be understood, a vast range of approaches within the focus areas that the San Francisco Children and Families Commission might promote and fund, and - because there are never enough resources to do everything - the tradeoffs that the San Francisco Children and Families Commission will face with every decision it makes.

Terms Used in The Initial Strategic Plan

Terms used in the strategic planning framework and throughout this Strategic Plan are often defined differently among and even within the focus areas. They are used in this Strategic Plan as follows:

Children 0-5: Children in their first five years of life, from birth up to age five. May also include the preconceptual and prenatal periods when preventive interventions can affect birth and infant health and developmental outcomes.

Children with Special Needs: Children with mental and physical disabilities or special health care needs.

Child Care: Primarily child care provided by caregivers who are licensed and paid or license-exempt and paid. May refer at times to informal arrangements by parents with relatives, friends or others who provide care of children.

Early Care and Education/Child Development: A focus area concerned with the child's status with respect to language, mobility, cognition, organization of experience, and psychosocial and affective development; services include child care at home and community sites (family day care, child care center-based care, and exempt care); preschool and Head Start programs; early intervention to prevent developmental delays; and services for children with identified special needs.

Child Health: A focus area that includes preconceptual counseling and family planning; prenatal, birth, and post-partum services; nutrition support; well-child and acute medical care; services for children with special needs; dental care; mental health services; domestic and community violence prevention; public health prevention services (lead; fires; unintentional injuries; immunizations; child abuse; etc.); physical activity opportunities; effective communities.

Early Intervention: Services to prevent further delays and to meet the developmental needs of each eligible infant or toddler and the needs of the family related to developmental delays.

Family: Anyone who carries the responsibility for raising a child.

Family Support: A focus area that includes parenting education and support, including information about child development; substance abuse and smoking cessation support; violence prevention; nutrition supplementation; literacy training; job and housing assistance; community capacity-building.

Focus Areas: A term from the State Commission that refers to the three

disciplines/professions/program areas concerned with health and development of children 0-5 and their families. The three areas are: Family Support; Child Development; and Child Health.

Health and Development (Health/Developmental): Physical health and development and cognitive, emotional, and social potential.

Infants/Toddlers: Children from birth to approximately 30 months of age.

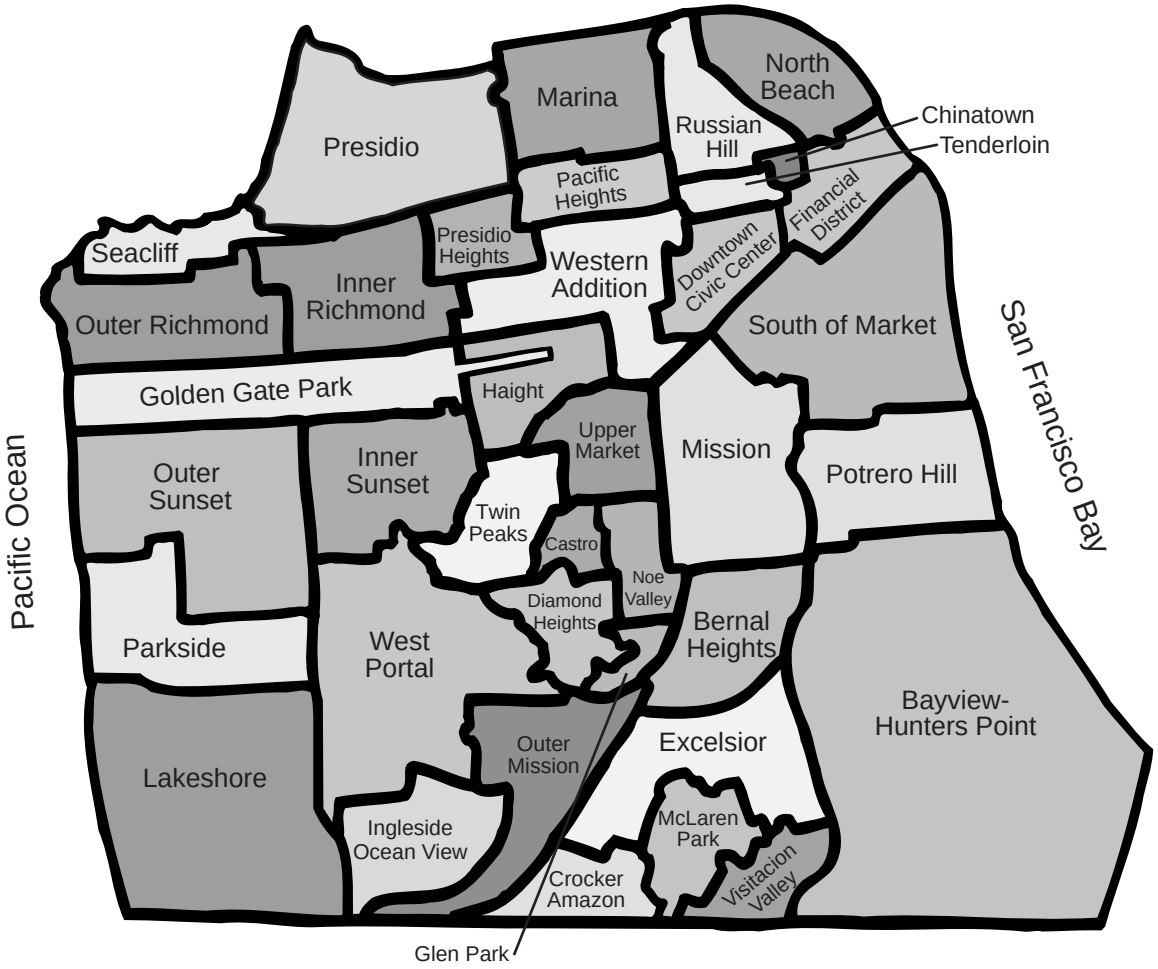
Prevention: An approach to child health and development which anticipates problems and addresses them before they become acute and therefore strives to minimize the need for intervention at any age.

Risks: Factors that prevent or inhibit health and development.

Strengths: Factors that promote or enhance health and development.

San Francisco Neighborhood: San Francisco neighborhoods evolve constantly and are not standardized across city/county departments. See Figure 2 for the map used in this Plan.

Figure 2. Map of San Francisco Neighborhoods 2000



PART II. DEVELOPMENT OF THE INITIAL STRATEGIC PLAN

Organization for Development of the Initial Strategic Plan

The nine Commissioners on the San Francisco Children and Families Commission were appointed in May 1999 by the San Francisco Board of Supervisors in accordance with provisions of the Act. They reflect San Francisco's diverse population, its well-developed child health and development sector, and its commitment to public-private partnership in planning and implementation of complex public policy. See Appendix 1 for a list of Commissioners.

The San Francisco Children and Families Commission established two committees to develop the Strategic Plan. The Strategic Plan Advisory Committee has 12 members, primarily child health, family support, and early care and education experts who are not Commissioners. It is chaired by a Commissioner. The Civic Engagement Advisory Committee has 18 members and is also chaired by a Commissioner. See Appendix 2 for a list of members of these two Committees.

The San Francisco Children and Families Commission developed this Strategic Plan in collaboration with pre-existing county and private agencies. Initial staff for the San Francisco Children and Families Commission came from the Department of Children, Youth and their Families (with support from consultants), which in turn worked very closely with staff of the Starting Points Initiative, a public-private partnership. (For a description of these agencies, see Part III.) In January 2000, the San Francisco Children and Families Commission hired its Executive Director, who worked with the California Center for Health Improvement (CCHI), the site of a Proposition 10 Technical Assistance Center, to identify a consultant to prepare the Strategic Plan.

The Strategic Plan Advisory Committee met regularly with the consultant as the Strategic Plan took shape, reviewed drafts, contributed text and background material, and held two retreats (full day in March, half day in June, both open to the public) to discuss key Plan elements.

The San Francisco Children and Families Commission heard regular reports of progress on the Strategic Plan from the Chair of the Strategic Plan Advisory Committee and the Executive Director. It reviewed and approved a "Community Discussion Draft 5/1/2000" of the Strategic Plan prior to its release for public comment throughout May 2000 (see below). It reviewed and approved the final Strategic Plan at its monthly meeting in June 2000.

Public Process

Development of the Strategic Plan benefited from a major commitment to public input concerning issues and needs of young children and their parents through a structured Civic Engagement Project. Funded in eight counties by a Bay Area foundation consortium, the Civic Engagement Project is jointly administered by the San Francisco Children and Families Commission and Starting Points. It enabled four unique opportunities for public input, as follows:

- **Telephone Survey:** 447 random, multi-lingual telephone interviews were conducted in San Francisco in 1999.[1]
- **Focus Groups:** Eight two-hour focus groups were organized and conducted at community sites with 63 parents and caregivers, including: Cantonese-speaking parents; grandmothers as primary caregivers; parents of children with special needs; lesbian, gay, bi-sexual, and transgender parents; families who are homeless or living in shelters or Single Room Occupancies; Spanish-speaking parents; and teen parents.[2]
- **Mail Survey:** Several thousand brochure-style questionnaires seeking information from parents to help the San Francisco Children and Families Commission planning were mailed and distrib-

uted through numerous organizations serving parents, including child care centers, clinics, family resource centers, etc.[3]

- **Community Conversations:** Ten two-hour, facilitated Community Conversations at community sites throughout San Francisco attracted over 100 participants, including parents, providers and community members. All conversations included Spanish and Cantonese translation, child care and food. Attendance at each Conversation varied from under a dozen to over three dozen community residents. Most of the Commissioners were able to attend at least one Community Conversation.

The Civic Engagement activities were complemented by customary and specially designed public processes in San Francisco to assure public input, including:

- **Public Meetings:** All meetings of the San Francisco Children and Families Commission (monthly) and its Strategic Plan Advisory Committee (at least twice monthly) and Civic Engagement Advisory Committee (monthly) were noticed and open to the public in accordance with San Francisco's Sunshine Ordinance. The Strategic Plan Committee retreats in March and June were noticed and open to the public. Members of the public spoke at all of these meetings The Commission also initiated a time-limited Ad Hoc Committee to address Infrastructure issues. Meetings of the Ad Hoc Committee were noticed and open to the public.
- **Public Hearings on the Three Focus Areas of the Act:** The San Francisco Children and Families Commission conducted three public hearings focused on Early Care and Education, Child Health and Family Support that helped lay the groundwork for the planning process. Local experts in the three focus areas of Proposition 10 provided theoretical and practical overviews of best practices and current gaps and opportunities in San Francisco. Public testimony from parents, caregivers and community providers were a key part of each hearing. Commissioners were able to ask questions and dialogue with presenters, and were provided with extensive background material in each of the three focus areas.
- **Public Hearing on the Draft Strategic Plan:** Conducted by the San Francisco Children and Families Commission on May 30, 2000 at City Hall, it attracted 16 speakers. The meeting was televised over the City's cable channel.

Legal Requirements

This Strategic Plan was developed in accordance with the requirements of the Act[4] and consistent with Guidelines approved by the State Commission in 1999.[5] With approval of the final Strategic Plan in June 2000 by the San Francisco Children and Families Commission, it was submitted to the State Commission, as required by the Act.

Development of the strategic planning process commenced in December 1999 and was completed in compliance with the ordinance that created the San Francisco Children and Families Commission. The original deadlines of April 1 and May 1, for draft and final plans respectively, were moved by the Commission to May 3 and June 14, 2000 to allow for full incorporation of the Civic Engagement Process.

Introduction to the Initial Strategic Plan

The Strategic Plan contains six Parts. Part I, Strategic Planning Framework, introduces the purpose of the Strategic Plan and some essential philosophical and conceptual background. Part II describes the process of development of the Strategic Plan as well as its contents in general. Part III presents a brief Environmental Scan to provide some context for the Strategic Plan from national-scientific and local-political perspectives. Part IV provides a Community Assessment, including the statistics and analysis that should inform decisions by the San Francisco Children

and Families Commission concerning allocation of Prop.10 funds. Part V details the Accountability Framework -the Outcomes, Objectives, Strategies, and Indicators - intended as the San Francisco Children and Families Commission's statement to the community concerning its approach to allocation of Prop.10 funds. Part VI presents Recommendations to guide the San Francisco Children and Families Commission investment decisions and previews the next steps.

Some technical notes:

- The statistical database for Proposition10 strategic planning is uneven and not centrally collected. Year 2000 census data will help to clarify some issues but many statistics of interest, e.g. developmental status of children 0-5, are simply not routinely available.
- All statistics are the latest available, which at times are still years behind the present.
- Age range follows conventional usage, i.e. "0-1 = zero through one year," EXCEPT when referring to the children of interest under Prop.10, who are always referred to as "0-5" meaning "prenatal up to age five."
- The required deadlines for production of the Strategic Plan prevented inclusion of any cost-benefit,
  sensitivity, what-if, or similar analyses to compare alternative objectives or strategies. It is hoped that future revisions will include such work.

A caveat: Information presented in this Strategic Plan comes entirely from secondary sources. The legal deadline for completion precluded either checking of old or solicitation of new data.

PART III. ENVIRONMENTAL SCAN

Scope of This Scan

Services and supports to promote child health and development comprise a major enterprise in the United States, California, and San Francisco. Theoretical foundations, policy, funds, services, professional training, standards of practice, and cultures span multiple federal, state, and local government departments, academic schools, and private agencies. Comprehensive description of this vast environment, an exercise that often opens a strategic plan, is outside the scope of this one. Rather, the Strategic Plan presents a quick summary of the contemporary case for intervention and of agencies supporting and serving young children and their families that precede the establishment of the San Francisco Children and Families Commission.

The Scientific Case for Services Dedicated to Children 0- 5 and their Families

"What would we call someone whose life's work has been the careful study of parents, caregivers, the subtleties of interpersonal interaction, the meaning of behavior, the parameters of cooperation and conflict and what constitutes an effective adult?

That someone is a baby. That is what a baby does: s/he studies all those things and has done so all his life, however old she is...Babies learn how to feel about themselves - whether they are important or valuable or can make anything happen. They learn quickly what to expect from the world and whether that world promises hope and…wonderment, or anguish and unrealized dreams.

The importance of the experiences of babies cannot be exaggerated. Indeed, scientific evidence has firmly established the lifetime contributions that positive - or negative - early experiences have in terms of shaping a child's self and world views. A community's dedication to the well-being of young children must begin at least as early as children's first precious interactions with the world around them."[6]

Two decades of research prove the newborn baby's brain is more active than most people thought. Infants interact with their environment before birth and from that moment on. For example:

- 6-month olds preferentially recognize vowel sounds prevalent in "parentese," the sing-song, exaggerated speech used by parents in many cultures to communicate and elicit attention;[7]
- even by 20 weeks of age, baby babble contains measurably distinct vowel sounds consistent with the language they hear.[8]

These infant responses correlate with growth of synapses among neurons in the brain.[9] There is consensus now that development of the newborn brain is molded, from birth if not before, by interaction with the environment.

Recent research further suggests that infant experience sets hormonal response levels for life[10] and that certain factors in early life, primarily nutrition, explain some mortality and morbidity patterns of individuals throughout their lifespan and of populations over time.[11] In other words, pre- and post-natal nutrition is a public policy, not just a parental, concern.

Early Childhood Strategies and Their Effectiveness

The science of early childhood development is rich in implications for strategies to be supported by the San Francisco Children and Families Commission but too young to point with certainty to the most effective ones. One reason is that evaluation of effectiveness requires unusual commit-

ment of professional resources and study participants over many years. Nevertheless, the list of strategies increasingly regarded as "basic" in the Proposition 10 focus areas of family support, early care and education/child development, and child health is growing, as suggested in the Terms in Part I:

- **family support:** parenting education and support, including child development; substance abuse and smoking cessation support; violence prevention; nutrition supplementation; literacy training; job and housing assistance; community capacity-building;
- **early care and education/child development:** child care at home and community sites, including family day care, child care center-based care, and license-exempt care; preschool and Head Start programs; early intervention to prevent developmental delays, and services for children with identified special needs.
- **child health:** preconceptual counseling and family planning; prenatal, birth, and post-partum services; nutrition support; well-child and acute medical care; services for children with special needs; dental care; mental health services; domestic and community violence prevention; public health prevention services (lead; fires; unintentional injuries; immunizations; child abuse; etc.); physical activity opportunities; effective communities.

Evidence of effectiveness of strategies is beginning to appear, for example:

- monthly home visits by nurses during pregnancy and for two years after birth to mothers at risk due to their youth, single status, or low income show measurable positive effects, both short-term (mother's hypertension; child injuries; second pregnancies) and 15 years later (child abuse; birth spacing; welfare term; mothers' substance abuse; mothers' arrests);[12]
- high quality child care programs (i.e. appropriate staff ratios, well-compensated staff, etc.) show "large short-term benefits…on intelligence quotient (IQ) and sizable long-term effects on school achievement, grade retention, placement in special education and social adjustment," according to a detailed review of 36 studies of small private and large public programs;[13]
- anecdotal evidence indicates declines in use of health services and high levels of parental satisfaction from innovative pediatric care strategies, such as multi-disciplinary primary care teams, availability of "developmental specialists" during doctor visits, promotion of reading, preparation for "transition points" in child development, and others.[14]

A leading epidemiologist summarizes the case for interventions:

"...child development affects health, well-being, and competence throughout the life cycle....evidence which can be derived from intervention studies in the post-neonatal, preschool, and school-aged period suggest that performance in two basic domains of child development, the cognitive and social-emotional, can be modified...[and] evidence from...long-term follow-up studies...strongly support[s] the view that they do improve long-term outcomes."[15]

The Accountability Framework in Part V and Appendix 3 builds on the basic strategies and points towards the San Francisco Children and Families Commission's need for evaluation of numerous creative possibilities.

Policy and Strategies for Children 0- 5 and their Families and Caregivers: A San Francisco Tradition

San Francisco is well-prepared to act on the implications of the science of early childhood development. Seventy percent of people participating in the Civic Engagement Project survey agreed with the statement that "the greatest amount of brain development takes place for children" from

birth to three years old.[16] Numerous local policies, government agencies, and private organizations have been promoting the health and well-being of very young children for many years.

The San Francisco Children and Families Commission thus enters a field well-supplied with principles and priorities. Some of the key players are described briefly below, both to demonstrate the depth of civic commitment to the very young and to provide important background for the San Francisco Children and Families Commission's own planning, resource allocation and advocacy activity. Not everything proposed, funded, accomplished or promoted is covered here. What follows is representative, not comprehensive.[17]

SAN FRANCISCO STARTING POINTS INITIATIVE

The San Francisco Starting Points Initiative is one of eleven Starting Points projects around the country created by the Carnegie Corporation of New York in 1996 and funded by several San Francisco foundations and DCYF. Starting Points is "a policy and planning project dedicated to improving the lives of young children and their families in San Francisco," with the goal of ensuring "that all San Francisco children enter school ready to learn."[18] It is directed by a multi-agency, public-private Early Childhood Interagency Council (ECIC) and housed in DCYF. Starting Points produced or assisted with production of several documents used to develop this Strategic Plan, including several strategic planning components.[19] It jointly administers the Civic Engagement Project with the San Francisco Children and Families Commission. Starting Points and its ECIC organize their work around three main outcomes:

- "Children and families are healthy;
- Children receive high quality child care and early education;
- Children live in safe, stable, supported families and communities."[20]

COLEMAN ADVOCATES FOR CHILDREN AND YOUTH

Founded in 1975, this private advocacy organization conceived and conducted the successful Proposition J campaign in 1991 to establish a Children's Fund from a dedicated set-aside of property taxes to fund programs for children and their families. In early 1999, it developed the "first ever budget for young children 0-5" in San Francisco.[21] The budget acknowledges the benefits of Proposition J but affirms that services for San Francisco's youngest children are "resource-starved."[22] To rectify this, it urges allocation of $21,850,000 among 18 priority strategies in four key areas:

- "Supporting child care providers;
- Building universal child care;
- Healthy beginnings; and,
- Family support."[23]

The largest proposed allocation goes to child care subsidies for working, non-CalWORKS families. Although each strategy is succinctly analyzed and some potential for leveraging state and federal funds is noted, no sources of funds are described. The budget is "submitted to San Francisco Policymakers" as a "blueprint for decision-making and resource allocation."[24]

CHILD CARE RESOURCE AND REFERRAL AGENCIES

San Francisco boasts two of the nation's first Child Care Resource and Referral agencies (R&Rs), Children's Council (1973) and Wu Yee Children's Services (1977). These state-funded agencies provide comprehensive child care information and referrals, training and support services, health and mental health consultation, Child Care Food Program, management of child care subsidy

vouchers, data and information. Services are multi-lingual, available at several locations, and are a basis for participation in planning and advocacy work in San Francisco and throughout the state.

SAN FRANCISCO CHILD CARE PLANNING AND ADVISORY COUNCIL

Mandated by state legislation in 1991 that enabled use of federal block grants for child care, the San Francisco Child Care Planning and Advisory Council (CCPAC) advises the California Department of Education on San Francisco's priorities for child care via development of a child care plan. Its first comprehensive child care plan is scheduled for publication in September 2000.[25] A recent needs assessment provides significant data for this Strategic Plan.[26]

HIGH RISK INFANT INTERAGENCY COUNCIL

A multi-agency, public-private network originally funded by the California Department of Developmental Services and currently funded by DCYF, the High Risk Infant Interagency Council (HRIIC) exists "to ensure that all children birth to three years…who are at risk for or who have developmental delays, receive family centered early intervention services…through interagency collaboration."[27] HRIIC serves as the interagency, parent-professional body for California's Early Start program in San Francisco.

DEPARTMENT OF CHILDREN, YOUTH AND THEIR FAMILIES

Established as the Mayor's Office of Children, Youth and Their Families (MOCYF) in 1991 to administer the Proposition J Children's Fund, DCYF's $26 million budget includes $18.3 million in FY 1999-2000 from the Children's Fund. These monies are distributed through an RFP process in accordance with a Children's Services Plan (CSP).[28] The CSP states that the mission of DCYF is "to bring together parents, youth, neighborhoods, city leaders, agencies, schools, the business community, and community services organizations to build the capacity of our neighborhoods to promote the healthy development of San Francisco's children."[29] In addition to grant-making toward this end, DCYF is investing in improved capacity for planning, evaluation and operations throughout its grantee community, which includes city departments. Although DCYF does not focus explicitly on children 0-5, its four "quality of life benchmarks" that anchor its outcomes-based planning apply to the very young as well as to older children and youth:

- "Children and youth are healthy;
- Children and youth are ready to learn and are succeeding in school;
- Children and youth live in safe, supported families and safe, successful, supported communities; and
- Children and youth contribute to the growth, development and vitality of San Francisco."[30]

DEPARTMENT OF PUBLIC HEALTH

Long established to protect and promote the health of all San Francisco residents, the San Francisco Department of Public Health (DPH) espouses a concept of "health" that includes social, economic and behavioral as well as medical components.[31] A recent assessment of the health and well-being of children and youth under the auspices of a DPH agency council with advice from a "report committee" that included Starting Points, University of California San Francisco, and the San Francisco Injury Center, provides substantial data and draws several conclusions of interest to the San Francisco Children and Families Commission.[32] The DPH Community Mental Health Branch (CMHB) has a Children, Youth, and Family Section that is responsible for mental health services for MediCal beneficiaries (who may be children 0-5 and their parents), that staffs a Primary Intervention Program (PIP) to provide early detection and prevention of emotional,

behavioral and learning problems in preschool children, and that collaborates with county agencies on special projects aimed at children and their families. The Division also provides funding for specialized mental health interventions for infants, preschoolers, and their families and is implementing mental health consultation and client services to more than 60 child care centers and 40 family child care homes.[33]

DEPARTMENT OF HUMAN SERVICES

San Francisco's Department of Human Services (DHS) administers numerous programs intended to assist parents and children, including CalWORKS, child protective services, foster care, subsidies for child care for CalWORKS participants, and substantial and innovative investments in building the capacity of the child care system. Its Family and Children's Services Division established and funds six community-based family resource centers and is collaborating with DPH's CMHB to establish the first Family Assessment Center in the United States.[34]

SAN FRANCISCO UNIFIED SCHOOL DISTRICT

In addition to its charge to run San Francisco's K-12 schools, the San Francisco Unified School District (SFUSD) is the largest provider of early child care and education for pre-kindergarten children in San Francisco through the Child Development Program (CDP), established in 1943 and funded by the California Department of Education. SFUSD also provides the sites, facilities and staff for five Beacon Centers at middle schools and several Healthy Start and other school-linked service programs that can function as family resource centers and community resources.

MEDICAL PROVIDERS IN SAN FRANCISCO: SAN FRANCISCO HEALTH PLAN AND BLUE CROSS

San Francisco is a MediCal two-plan county that requires nearly all MediCal beneficiaries to join one of two plans for delivery of health services (excluding mental health services). The public "local initiative" plan is the San Francisco Health Plan (SFHP), a Knox-Keene licensed health maintenance organization (HMO) that arranges, reimburses, and monitors health services for 4840 MediCal beneficiaries 0-5 and 1107 Healthy Family members 0-5.[35] Blue Cross is the private plan.

OTHER KEY PLAYERS

The Perinatal Forum; the Immunization Coalition; the Bringing up Healthy Kids Coalition; DPH's Coordinating Council for Children, Youth and Families; the Child Abuse Council; the Family Preservation and Support Planning Committee; the Family Resource Center Consortium; planners in numerous City Departments and other key players are all part of the fabric that supports young children and families in San Francisco.

This brief exploration reveals some characteristics that imply "a San Francisco approach" to planning and delivery of services for children and their families:

- a holistic view of child health and development as the product of multiple, complex factors;
- comprehensive direct services for children and families;
- solicitation of public participation in development of policy statements like strategic plans;
- inter-disciplinary and inter-agency collaboration;
- cultivation of strong relationships between government and private agencies.

This history offers the San Francisco Children and Families Commission a rich source of expertise and experience to support its own strategic planning. Indeed, many members of the San Francisco Children And Families Commission and its committees are long-time participants in the child health and development activities described above.

PART IV. COMMUNITY ASSESSMENT

Components of This Community Assessment

Guided by the strategic planning framework discussed in Part I, Part IV describes the demographics, the risks, and the strengths of families and the community relevant for planning for children 0-5 and their families. It then examines the gaps that the San Francisco Children and Families Commission could attempt to fill in the supply and quality of services within the three focus areas. Finally, it adds the community input, relating the spontaneous expression of needs to the framework.

Demographics

CHILD POPULATION SIZE, COMPOSITION AND DISTRIBUTION

San Francisco is home to 53,932 children age 0-5 (1998), seven percent of the total population.[36] The number of children in this age group has increased 51 percent since 1990.[37] The gender breakdown is virtually 50-50.[38] The racial/ethnic breakdown is:

Asian/Pacific Islander (PI):	19,450	36%
White:	15,672	29
Latino:	12,307	23
African-American:	6,389	12
Native American:	114	<1

Five San Francisco neighborhoods have 3,000 or more very young children: Inner Mission/Bernal Heights (5,724), Outer-Mission/Ingleside-Excelsior (5,265), Visitacion Valley (3,530), Sunset (3,490), and Bayview-Hunter's Point (3,066). Table 1 shows the numbers of very young in San Francisco's neighborhoods.

CHARACTERISTICS OF FAMILIES

An estimated 57 percent of children 0-5 - around 31,000 - live in households with two working parents or one employed single parent.[39]

Census data from 1990 display some trends important for the youngest children which bear watching as new census data become available:

- households with children have much lower average incomes than households without children;[40]
- 40 percent of families living below the poverty level have children under five (over 10,000 families);[41]
- ten percent of married couples, 16 percent of male-headed households and 45 percent of female- headed households with children in the home under five live below the poverty line.[42]

The San Francisco Children and Families Commission intends to analyze 2000 census data as soon as practicable to obtain a current picture of families with children 0-5 by: income, employment, marital status, neighborhood, education, and other socio-economic variables.

Many families with very young children are homeless: 2,800 such families need emergency or transitional housing in San Francisco every day.[43] In 1996-97, half the children in families calling Connecting Point (centralized intake for services for the homeless) were five or younger and over a recent two-year period, over half the children in family shelters were five or younger.[44]

Table 1. Estimated Distribution of Children 0-5 by Neighborhood in 1997

Zip Code and Neighborhood	Age 0-2	Age 3-5	Total 0-5
94110 Inner Mission/Bernal Heights	2,887	2,838	5,725
94112 Outer-Mission Ingleside-Excelsior	2,629	2,636	5,265
94134 Visitacion Valley	1,787	1,743	3,530
94122 Sunset	1,750	1,740	3,490
94124 Bayview/Hunters Point	1,522	1,544	3,066
94121 Outer Richmond/Sea Cliff	1,091	1,094	2,185
94118 Inner Richmond/Presidio/Laurel	1,076	1,105	2,181
94116 Parkside/Forest Hill	1,087	1,086	2,173
94117 Haight/Western Addition/Fillmore	850	905	1,755
94109 Russian/Nob Hill	870	873	1,743
94131 Twin Peaks/Glen Park/Diamond Heights	870	861	1,731
94102 Hayes Valley/Tenderloin	683	655	1,338
94133 North Beach/Telegraph Hill	664	656	1,320
94132 Stonestown/Lake Merced	653	664	1,317
94115 Pacific Heights/Western Addition	648	652	1,300
94127 West Portal/St. Francis Wood	632	650	1,282
94114 Castro/Noe Valley	451	456	907
94103 South of Market	451	448	899
94123 Marina/Cow Hollow	444	444	888
94107 Potrero Hill	425	439	864
94108 Chinatown	216	231	447
94111 Embarcadero/Gateway	29	20	49
94104 Financial District	22	18	40
94105 Downtown	25	8	33
94129 Presidio	0	0	0
94130 Treasure Island	0	0	0
Total	**21,762**	**21,766**	**43,528**

San Francisco Child Care Planning and Advisory Council, 1999.
1997 population projections based on 1990 U.S. Bureau of Census data.

The overall 0-5 population estimate on this chart differs dramatically from the State of California Department of Finance 0-5 population estimate. Different methodologies were used to determine the totals which result in vastly different population estimates. This chart is used primarily to illustrate the approximate distribution of children 0-5 by neighborhood.

CHILDREN SEPARATED FROM THEIR FAMILIES

Children in foster care are a vulnerable subset of the youngest children in San Francisco. Down from a 1993 high of 1,230, children 0-5 in foster care numbered 591 as of the latest count in May 2000. These very young dependents constituted over 50 percent of first-time placements in 1997, for which the predominant reasons were neglect (76 percent) and abuse (physical, 13 percent, sexual, 6 percent). San Francisco's foster care rate exceeds both Bay Area and state rates (which could indicate underuse elsewhere or overuse here).[45]

BIRTHS

There were 8,149 births to San Francisco residents in 1998 (about one per hour), a decline of nearly 20 percent since 1990.[46] The resulting birth and fertility rates are far below the state rates.[47] Two neighborhoods, Ingleside/Excelsior/Crocker-Amazon and Inner Mission/Bernal Heights, account for 25 percent of these births.

Five hundred births (six percent) were to teens age 13-19. One-third of these teen mothers, 199, were under 18 years old. Of the births to all teens 13-19, 74 percent were to Latinas (222) and African Americans (148).

Health Status

Perinatal mortality (28 weeks-7 days postpartum) was 76 in 1995,[48] for a rate of 8.8 per 1000 (live births+fetal deaths), which exceeds the Healthy People 2010 goal of 4.5 by nearly 100 percent.[49]

The number of low birth weight babies born in San Francisco (581 in 1998)[50] has declined over time, but at 7.1 per 1000 births, the rate exceeds the Healthy People 2010 targets of 5.0 (low) and 0.9 (very low).[51] In 1998, 86% of mothers initiated early prenatal care, with lower rates among African American, Filipina and Latina mothers.

Infant mortality (0-1) in San Francisco of 5.2 per 1000 live births exceeds the Healthy People 2010 goal of 4.5.[52] The current rate translates to over 40 deaths in a year, the leading causes of which - sudden infant death syndrome (SIDS) and birth trauma - are largely preventable. Boys die at a 40 percent higher rate than girls.[53]

Child deaths (1-5) average 12 per year,[54] a small number that nevertheless yields a rate of 34.6 per 100,000 that exceeds the Healthy People 2010 goal of 25 per 100,000.[55] The leading causes, congenital anomalies, homicide, traffic accidents, fires, and HIV/AIDS are largely preventable. Again, boys die at a 40 percent higher rate than girls.[56]

Illness in San Francisco children 0-5 is reported as follows:[57]

- unintentional injury requiring hospitalization=155 (1995);
- lead poisoning cases (blood lead >15ug/dL) in children 0-5=11,439 (1992-97);
- 43 percent of tuberculosis cases were in children 0-5 (1990-1996);
- 27 cases of AIDS in children 0-12, most of which are attributable to perinatal transmission prior to recent aggressive treatment of pregnant HIV+ mothers, who are now estimated to deliver only one HIV+ infant per year;
- severe, chronic illness qualifying for financial aid and medical services from California Children's Services (CCS) for children with special health needs affects 2,170 San Francisco children 0-5 (1998);[58]

- 532 children 0-5 with a DSM IV diagnosis are reported to be clients of DPH's Community Mental Health Services;
- one-third of children in public preschools had cavities in a recent one-time survey by DPH, with half of the children untreated.

Most illness among San Francisco children is unknown because it is not reportable to DPH or has not been surveyed by DPH. The most significant illness in children 0-5 for which there are no prevalence data is asthma. Asthma is the leading chronic illness of childhood, the first cause of hospitalization among San Francisco children 0-14, and a rising cause of childhood mortality nationwide.

Mental health[59] of the very young is deemed to be at risk in 12-14 percent of the population,[60] about 6,500 children based on the total number of children above.

Dental health, a new priority of the U.S. Surgeon General,[61] is unknown for the San Francisco population but can be assumed to be poor based on statewide and selected local statistics. A small study of children 2-55 months receiving Women and Infant Care (WIC) services at San Francisco General Hospital found early childhood cavities (ECC) or localized enamel demineralization in 38 and 17 percent respectively of the 146 children examined.[62] This means that fewer than half this sample of poor children had no sign of tooth decay. An additional risk for this population is untreated tooth decay in their mothers, 79 percent of whom reported active caries (which can transmit bacteria to the children through food, kissing, etc.). A comparable percentage of these mothers also reported access problems for their children's dental care. Statewide, California children have twice the dental disease as nationally and minority children have both a higher incidence of disease and less access to dental care.[63] It must be stressed that dental disease is almost entirely preventable.

Mortality and morbidity in the families of children 0-5, whether of parents, caregivers, or siblings, is unknown.

Developmental Status

Prevalence data for developmental and other special needs among children 0-5 are not available.[64] Starting Points has developed a desirable data set to better understand needs and services in this realm of child welfare, in particular:

- early identification and assessment of children with disabilities and special needs;
- inclusion of identified children in "natural environments";
- services and their coordination;
- routine data collection and standardization across systems.[65]

Utilization of developmental services by children at two of San Francisco's major providers is one proxy for the extent of special needs:

- Roughly 200 children 0-3 with "delay in development…likely to lead to a developmental disability"[66] were served daily from 1995-1999 by the city's lead agency under contract to the state Dept. of Developmental Services (Golden Gate Regional Center) to provide assessment, case management and purchase of direct services. (Older children remain eligible but the breakdown for 4-5 year olds is not available.) While diagnoses for children 0-5 are not available, mental retardation (a known sequel to premature birth) is the most common diagnosis (70 percent) for children 37 months-18 years.[67]

- San Francisco Unified School District (SFUSD), which provides "appropriate education" for children three and older regardless of type or level of disability and services for children under three with "low incidence special needs," had 626 children 0-5 in its special education program in 1998.[68]

Risks

Growth of children 0-5 into optimal health and development can be hindered by an array of risks that induce poor health or interfere with development. For example, a new US Department of Education study reveals that one out of three children admitted to kindergarten nationwide is unprepared for their first year in school.[69] The major risk factors for this are: having a single, female parent; living in non-English speaking homes; being in a family on welfare; and having a mother with less than high school education.[70] These and other well known risks to San Francisco children can be measured to some extent, as follows:

PARENTS' EDUCATION, LITERACY, AND LANGUAGE

Low levels of parental education and literacy and presence of non-English-speaking parents, known risk factors for lower developmental status of young children, are not measured by any source of data available to the San Francisco Children and Families Commission. Calculations based on Year 2000 census data will be useful when available.

POVERTY

Poverty is a universally acknowledged major risk factor for lifelong health and well-being.[71] An estimated 22 percent (1995) of children 0-5, in 1998 about 12,000 children, live in poverty in San Francisco. (The federal poverty level in 1999 was $16,700 for a family of four.) Poverty is exacerbated by the high cost of living in the city. For example, average monthly rent for a two-bedroom apartment ($1,500) is double the maximum CalWORKS (California's welfare program) monthly allowance.

CalWORKS, California's welfare program of income and assistance towards economic self-sufficiency, is one approach to mitigation of poverty and its consequences. In 1999, average monthly caseload in San Francisco (children 0-18) was less than half the number of children estimated to live in poverty: 5,677. The monthly caseload has declined steadily since a high of 13,091 in 1994.

The risk of living in poverty for a child 0-5 varies significantly by racial/ethnic group, if measured by the proportion of each group in CalWORKS. Over one-third (35 percent) of African-American children in San Francisco live in families receiving CalWORKS. All other groups show under seven percent of young children in CalWORKS except for Native Americans, at 15 percent.

The risk of a child's living in poverty is greatly increased by having a single mother. In 1990, 46 percent of female-headed households with children in San Francisco lived below the poverty line, compared to ten percent of married-couple families.[72]

Poverty is also a risk factor for intervention in the family by government. Reports of abuse and neglect are more likely to be followed up when the accused are poor than when they are not.[73] Whether this intervention is justified or excessive intrusion is controversial.

Although unemployment in San Francisco is at an historic low (2.5 percent), unemployment in the South Bayshore, Civic Center, and Mission areas is 9-13 percent. A growing concern in San Francisco, however, is the issue of sufficient income in order to afford the rapidly increasing cost of living in the City. The extent to which unemployment creates deprived living conditions for young children is unknown.

Since child support payments can be one source of income to keep poverty at bay, child support collection data are of interest. San Francisco tends to have a much higher percentage of "orders to pay" than elsewhere in the state but lower collection rates and lower average annual per case collection ($924 vs.$1140). Payments by age of child are not available.

RACISM

That race is a risk factor for health is well-documented in studies of health status and health access.[74] The resulting differences among racial/ethnic groups are termed "disparities" and are a major concern of national health policy.[75] Whether racism per se is a cause of the disparities is controversial. Given the prevalence of racism in American history and culture, however, it cannot be ruled out.[76]

Since children 0-5 and their families are clearly a multi-racial group in San Francisco, several disparities are well-documented:

- African American babies are born very low birth weight and low birth weight at 2-3 times the rates for all other groups;[77]
- African American and Latina mothers have similar first trimester prenatal care rates that are both 21 percent below the rate for white mothers;
- While African American children comprise ten percent of the target population, they comprise 69 percent of children 0-5 in foster care;
- Infant mortality for African Americans, at 14.8 per 1,000 live births, is almost triple the San Francisco rate of 5.2 percent;
- Rates of immunization for children by age 2 vary by racial/ethnic group from 77 percent of Asian children immunized to only 57 percent of African American children immunized.
- Cases of lead poisoning in children 0-5 vary substantially by racial/ethnic group within the low income population, ranging from 640 cases among whites to 2,863 cases among Latinos.[78]
- Use of services at Golden Gate Regional Center, for which there is no financial barrier (although there may be others), is over one-third greater for African American children 0-3 (25 percent) than for the next largest group, Latino, in turn one-third greater than for Asian children, in turn more than double the percentage of white children (5 percent).[79]
- Child users of mental health services are far more likely to be African American (30 percent of child users) or Chinese (22 percent) than white (12 percent).[80]

VIOLENCE

Domestic violence has multiple negative health and developmental consequences for young children. Child abuse is much more likely where there is adult violence; abductions are not uncommon, as is fleeing the home (with possible resulting homelessness). Chronic exposure to violence affects capability to learn and can compromise cognitive functions, relationships, and problem-solving ability. To date, data are scarce and not easily collected. The San Francisco Child Abuse Hotline (at the Department of Human Services {DHS}) averaged over 10 calls per day in 1990-1996 reporting physical and/or sexual abuse of children.[81] In 1999, 35 percent (2,640 calls, about seven per day) concerned children 0-5.[82]

SUBSTANCE ABUSE

Substance abuse by parents of young children can have adverse consequences, including before birth. Data on substance abuse by parents is not readily available. A study by the state Department of Health Services in 1992 of substance abuse by women at delivery showed that 11 percent of

women in San Francisco reported alcohol, tobacco, illicit drug or non-illicit drug use.[83] The rates for each of these categories were lower in San Francisco than state-wide except for non-illicit drug use, slightly higher. The San Francisco rates were: 6.6 percent for tobacco, 5.99 for alcohol, 3.47 for illicit drugs, and 2.35 for non-illicit drugs. (All such rates are liable to under-reporting). It is noteworthy that prevalence rates were generally higher for uninsured than insured women, for unmarried than for married, and for women lacking prenatal care.

ENVIRONMENTAL HAZARDS

Very young children are especially vulnerable to environmental hazards that weaken or poison their growing brains and bodies. Lead poisoning and asthma are two manifestations of environmentally induced disease. Since San Francisco ranks first in California for housing stock built before 1950 (when lead-based paint and lead-contaminated dust were common) and 94 percent of housing stock was built prior to the ban on lead in residential paint (1978), many city children are at high risk for preventable disease.[84] Asthma may be exacerbated by localized air pollution in southeast San Francisco, easily overlooked in a city generally cleansed by off-shore winds. This area is slated for major growth in the next decade and thus a predictable increase in auto exhaust, the largest source of air pollution in the city.[85]

Another source of environmental risk is hazardous material. A high concentration of military activities in past years leaves San Francisco with at least 25 "toxic hot spots" scattered throughout the city.[86] Several neighborhoods suffer high concentrations of hot spots,[87] however, suggesting higher risks than "average" for children in the city, thus:

Neighborhood(ZIP code)	**Number of children 0-5**
Bayview/Hunter's Point(94124)	3066
Potrero Hill((94107)	864
South of Market(94103)	899
Inner Richmond(94118)	2181
Polk Gulch/Russian Hill(94109)	1743
Inner Mission(94110)	5725

Strengths

Just as risks prevent optimal health and development, so certain strengths in families and in communities have been observed to create an environment in which young children can flourish. "Strength-based planning" and resiliency-based approaches attempt to recognize and systematize these observations.[88] So does the emerging discipline of "social epidemiology."[89] At present, however, most of the measurements and relationships that connect community characteristics to health and developmental outcomes among children and families are not well-developed.[90] While the factors described below make intuitive sense as precursors to successful child-raising, there is only limited evidence of precise connections.

PARENTAL HEALTH, EDUCATION, AND LITERACY

No information is available to describe these inherent strengths that San Francisco parents bring to their tasks as parents.

ADEQUATE INCOME

Income is a primary predictor for lifetime health status and mortality.[91] Although San Francisco is an expensive place to raise children, some can afford it, since median family income in 1999

was $68,600. As noted, however, roughly 12,000 children 0-5 live in poverty and thousands more live between poverty and the median. This again emphasizes the issue of adequate income in San Francisco to provide for basic needs such as housing, food and health care, and to afford to either receive or provide early childhood and family services and supports such as child care.

JOBS

Income being a critical variable for early childhood health, job availability is clearly a community strength of interest. Unemployment in San Francisco is at record low (2.5 percent) and job creation is high. It is reasonable to assume that this vigorous economic situation is benefiting young children through family income and the psychological benefit to parents of working. As noted above, however, obtaining employment in San Francisco that provides adequate or sufficient income to support family needs is becoming a growing concern. A result of increased employment of parents is the urgent need for affordable and quality child care among San Francisco's estimated 31,000 children 0-5 living with working parents. (See below).

HOUSING

While lack of housing is not always considered in planning for child health and development, the historical reason for ignoring it has been the assumption of its existence. San Francisco is notoriously short of housing, especially affordable housing. Median sales price, increasing steadily for over a decade, now stands at $407,000. Affordable rental housing is virtually non-existent. Homelessness is a constant threat to low and moderate income families.[92]

NUTRITION

Nutritional status of children 0-5, an obvious dimension of health and developmental status, has never been measured in San Francisco. Seventy-four percent of children eligible for nutritional supplements under WIC received this assistance, a penetration rate higher than the statewide of 68 percent.

HEALTH INSURANCE

Health insurance facilitates access to health services, especially to a "medical home," a known correlate of better health status.[93] Health insurance or some type of coverage for children 0-5 is available from several sources: MediCal, Healthy Families, Access for Infants and Mothers (AIM), private coverage through parents, and various government programs with varying eligibility requirements. Access to low cost dental care remains a concern in San Francisco. Lack of insurance among children in San Francisco, unmeasured at present, will soon be quantified by the California Health Interview Survey, scheduled for completion in 2001.[94] Available statistics are as follows:

- coverage for births, virtually 100 percent through either state or private programs, was 97.1 percent in 1997;[95]
- 15,200 children 0-5 are covered by MediCal and 6,249 by Healthy Families, which accounts for 40 percent of children in this age group;
- over 20 percent of children 0-5 eligible for preventive health screening through Child Health and Disability Prevention (CHDP) were screened in 1996-97, with infants 0-1 yielding the highest number of children with potential or confirmed health problems (2,217) compared to other age groups.[96]

Empirical data suggest that continual outreach is needed to find every eligible child, particularly in the immigrant communities in the City. The perennial problem of lack of health coverage was

recently addressed in San Francisco by a Mayor's Blue Ribbon Committee.[97] Its leadership is pursuing implementation.

EARLY CARE AND EDUCATION

Child care is a necessity for working parents, including parents on welfare transitioning to work, and a desired service for many non-working parents. Historically the purview of a huge array of state, local, and private agencies,[98] child care and early education are provided in San Francisco by the following types of agencies:

- licensed child care and child development centers, including Head Start and preschool;
- licensed family child care providers;
- license-exempt providers (typically relatives or neighbors).

The current child care system is complex, with funding coming primarily from state and federal sources. In San Francisco, planning for child care has been conducted over the years by the Mayor's Advisory Council on Child Care, the Child Care Committee of the Mayor's Welfare Reform Task Force, the Starting Points Initiative and others. Given the large need, numerous agencies, diverse sources of funds, and a current state mandate for planning, comprehensive local planning for child care is a necessity. The state mandated child care plan is scheduled for publication in September by the Child Care Planning and Advisory Council.

The current estimate of licensed child care capacity in San Francisco for children 0-5 is 11,400 slots in child care centers, and approximately 2,250 slots in family day care homes based on estimates of the ages of children in care. Thus there is a total licensed capacity for children 0-5 of approximately 13,650 slots.[99] This translates to 4 children 0-5 per space or 253 slots per 1,000 children 0-5.[100] There are no national or state standards for adequate child care capacity. Significantly, the demand for child care among non-working parents is unknown, complicating calculation of "gaps." Vacancies currently exist in San Francisco, particularly in family child care homes. The CCPAC plan should provide an authoritative estimate of spaces needed. Because the cost of licensed child care is often beyond what many working families can afford to pay, the availability of subsidy assistance is as critical an issue as the number of spaces.

In addition to the fundamental issues of whether there is an adequate supply of child care and the resources to help parents pay for care, analysis of the situation requires attention to the issues of accessibility, quality, availability of care for transient emergency situations like mild illness, the ability of programs to care for children with special needs (dietary, chronically ill, etc.), and low pay and training needs of child care providers. (See further discussion below.) The few longitudinal studies of the effects of high quality child care programs have found measurable benefits to children who participated in such programs. A 1999 report from the "Abecedarian Project," ongoing since 1972, found that children receiving high quality child care (low student-teacher ratios, well paid teachers, low turnover, children starting at 6-16 weeks of age) had better academic scores throughout schooling, completed more years of school, and started families later than the control group who received care in a miscellany of child care arrangements.[101]

FAMILY SUPPORT

Family Support programs attempt to "fill the gaps that families today are experiencing in their support systems…[with the goal of] empowering and strengthening adults in their roles as parents, nurturers, and providers…"[102] Extensive research on resilience and child development has clearly shown that what is needed for normal child development and behavior is strong and pas-

sionate parent/caregiver support. The focus area of family support and parent education recognizes that all parents need support to become this source of strength and guidance for their children. Peer-based family support can be:

- an effective tool to help parents work through their problems and get assistance;
- parent-centered and directed, involving professionals as consultants to parents;
- a place to develop community and serve as a type of extended family;
- flexible and easily adaptable to different settings and needs of diverse families.

With diverse origins in 19th century settlement houses and PTAs and 20th century Head Start and self-help groups, the family support "movement" has recently codified a set of "premises" and "principles" to unify a large range of agencies, programs, and practices to "advocate a new commitment to families."[103] Core services include: parent support groups and education, child care, life skills training, family counseling, family activities, resource and referral, auxiliary support (food, clothing, transportation). The concept received federal support in the Family Preservation and Support Act of 1993 that funded preventive services to preserve and strengthen families.[104] This funding is administered in San Francisco by DHS.

Family Support programs, services and supports are provided in a range of settings, including family resource centers. Some may be neighborhood-based; others may focus on the needs of certain groups of families and their children. For example, in California, family support services have been developed that specialize in support for children 0-3 with disabilities or at risk for disabilities and their families.[105] These services, funded by the federal Individuals with Disabilities Education Act (IDEA; 1987), are offered by California's Early Start Program through the state Departments of Developmental Services (DDS) and Education. The intention is early intervention following identification of disabilities.

Family support programs in San Francisco include three classes of agencies:

- six Family Resource Centers (FRC) initiated and funded by DHS which serve geographically and ethnically defined families with children 0-5 with the goal of strengthening and stabilizing families and preventing admission into foster care;
- eight agencies with diverse programs, aimed city-wide or more locally, funded by government and foundations, which formed the Family Resource Center Consortium (FRCC) in 1995;[106]
- numerous organizations throughout San Francisco, including the child care resource and referral agencies, family service agencies, parent school-based Beacon Centers and early care and education programs that provide services characteristic of FRCs but are not self-identified as a FRC.

FRC agencies served from 474 individuals to 6,000 families in FY1997-98.[107] Total families served or benefited is unknown, although efforts are underway to explore data linkages between sites.

Family support is also an approach to provision of services to families.[108] As such, it has begun to influence how services are offered to families in San Francisco.[109] Two indicators of effectiveness are reduction in removal of children from their parent(s) and reunification of children with their parents by DHS. San Francisco's foster care placement rate of 16.6 per 1000 children 0-17 (of whom 24 percent are less than five) exceeds both state and Bay Area averages but is reportedly declining.[110] Recent reunification statistics for all children (age not available) are: 12 reunifications in 1996; 80 in 1997; and 328 in the first half of 1998.[111]

EFFECTIVE COMMUNITIES

The concept of effective communities points to characteristics of neighborhoods that enhance strengths and diminish risks to children and families. Such characteristics include: parks and associated programs for recreation, exercise, and breaks from passive pastimes such as TV and computer games; access to healthy food; restraints on advertising and access to addictive substances; control of environmental hazards; prevention and control of crime; opportunities for civic participation and the myriad informal connections that create a sense of community. Since no one document presents all this information in one place for San Francisco, further description of community effectiveness is anticipated in the next round of strategic planning.

Summary Picture of Child Health and Development

The information now available concerning San Francisco's youngest children suggests the following summary picture:

- the population 0-5 has grown substantially in the last decade (primarily from in-migration, since the fertility rate is so low) and may continue to do so as the city's population grows with new residents in their child-bearing years;
- systematic information about the parents of children 0-5, their most important resource, is almost completely missing;
- probably 20 percent or more of children 0-5 (about 12,000) are subject to significant risks from poverty and the parental problems that can accompany lack of income in a wealthy society: substance abuse, violence, poor health, lack of involvement in the child's development, homelessness;
- large racial/ethnic disparities in health status and developmental problems exist, especially among very young African American and Latino children;
- more than half of San Francisco children 0-5 (57 percent) live in households where one or both parents in San Francisco work;
- child care, a necessity of life for working parents in San Francisco and a desirable service for many others, is a complex system both in terms of available services and the resources to pay for them;
- the extent to which lack of health insurance prevents access to needed health and developmental services is unknown;
- CHDP screening consistently uncovers treatable health problems that worsen when neglected, including physical, dental and developmental problems, but screening does not reach many eligible children;
- lead-laden housing and environmental hazards distributed throughout the city may cause health and developmental problems in very young children but not all families are aware of the hazards or the ways to ameliorate them;[112]
- there is no systematic collection of population-based data to measure the health and developmental status of children 0-5 or community-level data to support planning for optimal health and development of children 0-5 and their families.

These findings summarize the challenge that Proposition 10 was created to address: to improve this picture by investing either in existing systems that lack resources or in new approaches. The Proposition10 focus areas direct attention to existing systems: family support, early care and education/child development and child health, all of which are richly developed in San Francisco. From this perspective, the demographics, the risks and the strengths relevant to children and their families imply some "gaps" that the San Francisco Children and Families Commission could fill, as discussed below.

Gaps in Services for Children 0-5 and their Families by Focus Area

FOCUS AREA: FAMILY SUPPORT

Many needs expressed by the focus groups and during the Community Conversations fall under the family support rubric, suggesting the importance that families and communities place on family support strategies. It is also asserted that family support for women in jail and released from jail is lacking, preventing family reunification upon their release.[113] The consistency of such statements adds to their significance, especially since there is no comprehensive, citywide information available at this time concerning gaps in services or evaluation of quality in this focus area. San Francisco does have established family resource centers scattered throughout the city. As described previously, they have been developed through a variety of means, including the federal Family Preservation and Support Program. These FRCs may focus on serving a particular neighborhood or population, although several provide services and supports that reach families across the city and all have adopted the principle of universal access to any family. There are some neighborhoods in San Francisco without a locally-based FRC.

Nationally, work is well underway to develop standards for family resource centers and support services. The family resource centers in San Francisco have all adopted the nationally-established principles for FRCs, and some have been pilot-testing evaluation based on the national standards. The development of the Family Resource Center Consortium, and the linkages between the DHS developed and supported FRCs provide ongoing opportunities to build on and work toward a citywide approach to understanding gaps and development of effective services. The DHS FRCs will be evaluated by a private firm under contract to DHS, providing the first such assessment in this sector in San Francisco.

Parent education, a key component of family support, is currently provided in a variety of venues throughout the city. Families and providers of this service have identified the need for increased opportunities, better coordination and accessible information about parent education.

FOCUS AREA: EARLY CARE AND EDUCATION

Child Care

Gaps in child care, brought into sharp focus by San Francisco's booming economy and the reorganization of welfare to require training, work search, and work, can be analyzed in terms of four key issues, as follows:

Child care capacity

Since child care capacity has increased by over 1,200 slots since 1996,[114] the primary capacity issue at present for children 0-5 involves spaces for infants.[115] This gap presents particular challenges, due to the intensity and sensitivity of infants' needs. The current estimated gap is approximately 1,500 infant spaces, based on available capacity of 1,000 existing infant slots.[116]

A crucial factor in analysis of child care capacity is parental preferences, which have not been surveyed in San Francisco. Analysis of need could be simplified by an assumption that number of places should match numbers of children in working families plus some number of non-working parents.[117] However, not every working parent may be seeking child care and the preferences for specific types of care of those who are have not been measured. Response to any demand for child care must account for differing program needs by age of the child as well as disparities in capacity and demand by neighborhood.

Additional supply-side factors important for planning child care capacity are emergency back-up, care of children with special needs and their siblings, and care during non-traditional hours. Parents need respite care, there are few options except parental care for mildly ill children, and little provision is available for emergency back-up care. The chronic health care needs of some children (e.g. deafness, asthma, specialized nutrition) demand permanent capacity for care for this population of children. Many parents work outside traditional working hours, while typically both child care centers and family child care homes operate during the traditional work week. Some capacity to accommodate non-traditional need is available and DHS and others are attempting to respond to these needs.[118]

A final capacity factor is capital to increase and renovate child care facilities. Child care providers generally cannot afford to borrow at market rates, leading to a pressing need for grants, loans, and loan guarantees. San Francisco has responded to this need with the Child Care Facilities Fund, a public-private collaboration established in FY1998 with city, private and federal (Housing and Urban Development Section 108) funds for grants, loan subsidies and technical assistance for both child care centers and family child care homes. The Fund is administered by the Low Income Housing Fund, a private, non-profit housing lender.[119] Over 1,000 licensed slots are being developed in high need areas with these funds.[120]

Child care affordability

Child care in San Francisco is a major expense for many parents. A parent working full-time at minimum wage could spend, on average, 63-93 percent of her wages on child care.[121] At income brackets around the median, child care can cost 20-30 percent of a family's income.[122] Despite the high cost to families, providers receive very low wages and reimbursement levels for infant care often do not cover the cost of providing services (see below).

Subsidized child care in San Francisco is provided in state funded child care centers, including the child development program of the San Francisco Unified School District, and through the provision of vouchers that allow families to choose the type of care they prefer. The federally funded Head Start program provides part-day, part-year programs for very low income families, although expansion plans include the provision of more full time, year round care. In addition, children of low income families are served in part-day state preschools. Approximately $35 million in subsidy payments are available to child care centers serving low income families in San Francisco. An additional $26 million is available through vouchers for CalWORKS families, plus $1 million in state CDE funds for non-CalWORKS families and $2 million in city general funds for vouchers for non-CalWORKS families with a priority on family child care options. (These totals include subsidies for school age children as well as for children 0-5) Many working parents who qualify for subsidies do not receive assistance. Multiple waiting lists throughout the city show 6,000 parents seeking subsidies for child care. The availability of subsidies is a major issue in San Francisco because of the high cost of living in the City. About four percent of eligible children 0-2 and 65 percent of eligible children 3-5 currently benefit from existing subsidy programs.[123]

Child care accessibility

The complexities faced by parents seeking access to child care are exacerbated in California by lack of a centralized eligibility mechanism in each county that would eliminate the current requirement that parents looking for a subsidized space sign up in multiple locations to get on lists for openings as they appear. This need is now being addressed through a project of the Child Care Planning and Advisory Council. San Francisco's financial commitment for the project may potentially be matched with state funds.[124]

Access to child care services for parents in San Francisco is complicated by public transportation barriers. A recent study by the Metropolitan Transportation Commission illuminates grave problems for low-income families who use public transportation to get to child care (sometimes multiple sites for different age children) and work. Especially for after-hours workers, for single parents, and for workers who have no flexibility in their work hours, transportation is a major issue.[125] A preliminary plan to address this problem in San Francisco is complete, but the required flexibility will be a challenge for the city's public transportation system.

Child care quality

Quality in child care has several dimensions that imply gaps of potential interest to the San Francisco Children and Families Commission. The first is remuneration (wages plus benefits) of child care workers. Adequate compensation is needed to attract and retain qualified professionals in the field of early care and education. The field is notoriously underpaid and turnover is high. A provider health benefits pilot is underway in the city to provide access to health insurance for child care providers and subsidize the cost of premiums for low income family child care providers.

Professionalization in San Francisco is supported by two programs:

- California's first Compensation and Retention Encourages Stability (CARES) Initiative provides $1.15 million in local funds for financial incentives for continuing education of child care workers in all licensed settings;[126]
- High Quality Child Care Initiative, administered by DCYF in partnership with DPH and DHS, supports training, mental health consultation, quality enhancements in license-exempt settings, and establishment of a centralized list for child care placements and subsidies.[127]

A second dimension of quality relates to the content of the care provided. Research shows that high quality programs manifest both short and long-term benefits in terms of children's skills, readiness to learn, and behavior, with some evidence of greater gain for those most at risk.[128] Characteristics of high quality care include low adult:child ratios, continuity of staff, and basic and continuing education of staff in child development. The CARES program begins to address the need for training by providing financial incentives for education in child development and longevity in the field.

A third dimension of quality of child care involves a link to mental health resources for children, families and caregivers. A 1999 survey of family child care providers is the first to assess the nature and extent of this need.[129] The highest priority problem for providers was behavior, followed by asthma as the most prevalent health problem. As noted in Part II, the Children, Youth, and Family Section of DPH is now implementing mental health consultation and client services to more than 73 child care centers and 65 family child care homes.[130] The Maternal Child and Health Division of DPH, in collaboration with DHS, has also initiated a project to link public health nurses with child care settings.

A fourth dimension of quality – the quality of the physical environments where children spend their days – is being addressed through the Child Care Facilities Fund. (See above.)

In summary, efforts to respond to the need for child care in San Francisco are numerous and ongoing, but significant problems remain. For example,

- the median hourly wage for family child care providers is said to be at or below minimum wage;[131]
- the Facilities Fund received over 100 requests for over $600,000 in its first year but could fund only 23 for $100,000;[132]

- the cost of full-day infant care averages $11,000 per year, beyond affordability for many parents and exceeding state reimbursement rates.

The state mandated planning process taking place under the auspice of the Child Care Planning and Advisory Council will help to guide investment in this focus area, and bring further clarity to the gaps in child care of potential interest to the San Francisco Children and Families Commission.

Early Intervention To Prevent Developmental Delays

San Francisco has several early intervention programs through the Early Start Program. In addition, efforts have been made to increase opportunities for early intervention and integrated services and supports within natural environments such as child care. Overall, a major systems issue remains the lack of a family-centered, comprehensive, multi-disciplinary and coordinated early and periodic assessment system for all young children. The pending closure of Division of Development and Behavior Pediatrics at UCSF increases the gap in available resources. A major referral, training, and research site for pediatricians in child development and behavior, the UCSF waiting list is typically two months long and about a third of its patients are under five.[133] Child development services are rarely eligible for reimbursement by private insurance, however, and public payment does not cover the cost of care.

Services For Children With Identified Special Needs

Families of young children with special health care needs face a service system replete with complexities, fragmentations, and multiple, non-communicating layers. Uncoordinated policies, regulations, and procedures that govern public and private agencies confuse parents and professionals alike. Further, the medical community often has limited understanding of the programs and services available and agencies themselves are often unaware of what others may offer. A frequent result is that time-sensitive services for young children are delayed while parents learn to navigate the system. This includes timely referrals to needed specialists, and lack of comprehensive early and periodic assessment as mentioned above. Some children fall through the cracks, their risk status unidentified until they reach school, thereby losing precious years of developmental growth.

The role of the family as a key player and decision-maker in design and implementation of services for the child has received some attention but much more needs to be done. Families need information, education, and support in order to advocate effectively, particularly regarding legal mandates, requirements, and rights. More experienced parents in turn can help less experienced, as well as providing guidance to professionals as all seek to make the system more user-friendly.

Coordination, collaboration, and linkages within and between agencies and with families are a pressing need. Both inter-agency and parent-professional collaboration should result in earlier and more precise identification of children who have, or are at risk for, developmental delays and in improved services to these children and their families.

FOCUS AREA: CHILD HEALTH

Gaps in child health services result primarily from stubborn barriers that would benefit from persistent, reliable funding, rather than major infusions.

Parental Health

Parental health as a health concern may be the exception meriting significant attention. An unknown number of parents of children 0-5 have poor physical and/or mental health, substance abuse problems, illiteracy, extreme burdens from combinations of work, school, multi-genera-

tional obligations, other children with severe problems, etc. Since parents are a child's most significant defense against the risks of early life, parents suffering from poor health, fatigue, overwork, worries of every description, put their children at risk as well. Help for parents in such situations would, almost by definition, promote the health and development of their youngest family members.

Parental Behavior

In the concluding comments of its extensive study of child health in San Francisco, DPH notes that most problems with health and development of children 0-5 reflect "their extreme vulnerability and dependence on adult caregivers." Gaps in services for this population that relate to behavior of their parents include:[134]

Prenatal care

Eighty-six percent of San Francisco mothers start prenatal care during the first trimester, just short of the Healthy People 2010 goal of 90 percent.[135] Disparities in use of this service by racial/ethnic group persist despite great progress over decades. In considering the seriousness of this problem, it is important to note that some experts question the benefit of raising this rate, contending that only environmental interventions far beyond traditional prenatal care can improve birth outcomes.[136]

Immunization

Health of children 0-5 is protected through immunization in the first two years for 70 percent of San Francisco children, a steadily rising rate but still well below the Healthy People 2010 goal of [90 percent]. Racial/ethnic disparities are present, although rates for all groups are rising: 57 percent of African American (1999) and 63 percent of Latino children (1999) immunized, compared to 71 percent of Asian (1998) and 68 percent of white (1998) children.[137] It is interesting that immunization of Chinese girls is statistically significantly lower than for boys.[138] There is no question of the benefit of immunization, although exact data on resulting illness (and its costs to children and parents) are not available.

Violence

Virtually to the point of publication of this Plan, large-scale intervention to prevent and treat domestic violence affecting children 0-5 did not exist in San Francisco. As of FY 2000-2001, however, the U.S. Department of Justice has awarded a $670,000 Safe Start grant to DCYF to initiate a program.[139] Components include: screening families of all newborns at San Francisco General Hospital for risk; home visiting; treatment of children and families for exposure to violence, especially children already removed from home because of violence; and training of parents and professionals, including law enforcement, to prevent violent behavior. Gaps in capacity may be revealed by implementation of this program.

For many parents, visits to the pediatrician may be a young child's only contact with any "system" that might detect and intervene with problems related to violence. Whether pediatricians practicing in San Francisco are knowledgeable about and following new guidelines from the American Academy of Pediatrics concerning violence by and to children is unknown.[140] Physician contact has been proven effective in changing adult behavior but training physicians to increase their scope of services is a challenge, especially if it is perceived that changed behavior is not rewarded. The Safe Start grant may produce some information on this important entry point for violence detection and intervention.

Mental health services
These services for the very young are now utilized by just over 500 children 0-5.[141] Since estimated prevalence of problems suggests that services are reaching less than ten percent of the target population, parents and caregivers may be unaware of danger signs or unwilling to seek help for them. Access to mental health services can be problematic for low-income children, including long waiting lists and lack of providers willing to accept the MediCal reimbursement rates.

Health insurance
An unknown number of parents whose children are eligible for MediCal or Healthy Families have not enrolled them. Continual outreach is needed to find every eligible child, especially for families who are new immigrants.

Capacity Weaknesses
Some gaps in health services reflect chronic shortages of resources or commitment or both. These include:

CHDP screening
CHDP screening reaches only about 24 percent of estimated eligible children, which includes MediCal beneficiaries from birth, children in low-income families from birth, and children 3-5 in Head Start or preschool. At this rate of screening, about one-quarter of children have identified medical, dental, nutritional, vision, and developmental problems.[142] This suggests CHDP is a fairly effective but relatively rare intervention for early detection of risks to poor health and development.

Dental Care
Availability of low cost dental care for young children in San Francisco remains an issue for families.

Employer-based health insurance
An unknown but potentially countable number of San Francisco employers with employees who are parents of young children, including child care providers, do not offer health insurance, or offer it but pay nothing towards premiums that are unaffordable for parents, or do not offer and/or pay for dependent coverage. Subsidies and a purchasing pool are the key recommendations to rectify this gap from the Mayor's Blue Ribbon Committee on Universal Health Care.[143] These recommendations are being pursued by its leadership.[144]

Home visiting
An unknown number of pregnant women, young children, and families might benefit from home visiting. Newborns in California are required to receive a home visit if discharged when younger than 48 hours for normal birth or 96 hours for C-section. There is no reporting of home visits, so the total number of children, families, and visits is unknown. Gaps in this service are believed to exist, however, due to the prevalence of high caseloads (20-25 families per home visitor) compared to national benchmarks (10-15), the lack of stable funding, and the stigma that may be associated with home visiting when it is not universally offered.[145] A recent informal study found the number of babies born in San Francisco hospitals who receive at least one home visit after birth ranges from 25 percent (at California Pacific Medical Center) to 85 percent (Kaiser), with the visits provided by a large number of private agencies and DPH.[146] The same study cites hospital sources who say that visits are routinely denied for coverage by

private insurance (or by the mother's medical group). It is stated by San Francisco home visiting experts that universal coverage does not exist.[147]

Lead screening
Blood lead screening, initiated by DPH in 1991, is only reaching an estimated 5-15 percent of the population at risk.[148] Children one and two years old are at highest risk for lead poisoning, which affects cognitive and behavioral response and can lead to coma and death. This problem is entirely preventable but fairly prevalent due to aging housing stock, as noted above.

In summary, gaps in services to promote child health are generally well-documented, although not conveniently quantified anywhere. Closure of these gaps could contribute to achievement of several Healthy People 2010 goals.

Community Perceptions: Input from the Civic Engagement Project

Findings and Recommendations from the Civic Engagement Project merit special attention in the San Francisco Children and Families Commission's Community Assessment. For all the statistics and analyses by professionals and politicians, parents are the ultimate source of understanding what needs to be done to enhance the health and development of their children. Many of the Principles stated in Part I require constant surveillance of parents' needs to ensure responsive investment by the San Francisco Children and Families Commission. Results from the focus groups and from the community conversations during this first cycle of strategic planning are reported below.

INPUT FROM THE FOCUS GROUPS

The following findings and conclusions are taken directly from the report of the consultant, contracted through the project to conduct the focus groups.[149]

Despite large demographic differences in the characteristics of the parents, all parents want:

- Better information: a single number; a real person to listen; specific advice; child care and family support options were of special interest.
- More accessible child care: affordable; near by (transportation being a serious problem); infant/toddler care; respite care; non-traditional hours.
- Parenting support and education: especially for grandmothers raising "modern" kids, teens with no prior experience, and immigrant families grappling with different cultural norms and expectations regarding child rearing and development; workshops or other instruction to address specific needs, including anger management, appropriate discipline, day planning, educational mentoring skills, and cultural training;
- Support groups: to remove feelings of frustration and isolation among many parents, the groups should be issue-oriented, not forums for generalized skills training.

Specific needs were expressed by parents in several groups, revealing some problems in common within hard-to-reach groups of parents:

- Concern for safety: includes both community (streets and parks) and family settings (domestic violence),[150] especially for grandmothers, teens, families who are homeless, and Spanish-speaking parents;
- Professionals untrained for specialized needs: parents of children with special needs are critical of the systems (social and medical) presumably serving them and lesbian, gay, bi-sexual and transgender (LGBT) parents find adoption services ignorant of the law and of this parent group.

The former want child care adapted to their children's needs, an ombudsperson who could advocate across program boundaries, and a more holistic and coordinated approach to children with special needs in the educational system and across systems. The latter want "social workers and child care workers to understand the needs of gay parents and at least understand the law";[151]

- Transportation: the lower the income, the more pressing the need for flexible and timely options;
- Sensitivity/respect: teen parents, parents who are homeless, LGBT parents, and parents of children with special needs report lack of understanding from professionals about the stresses they deal with constantly;
- Job training: parents who are homeless, teen parents, and immigrant parents are eager for income to solve many other problems;
- Safe/accessible playgrounds: policed, equipped for children using wheel-chairs and other adaptive equipment;
- Child development: nearly all the parents stressed desire for their children to have the best mental and social development;
- Domestic violence: experienced by teen parents and Latinas who attended these particular focus groups, feared by many, already an influence on the grandchildren of the grandmothers.

Based on these concerns, the Civic Engagement Project's consultant for conducting and analyzing the focus groups makes these recommendations:[152]

1. Create an information hotline and clearinghouse for parents providing a variety of information
2. Conduct "social marketing" campaigns (i.e.: specific theme, in tailored locations and languages, featuring a single contact number)
3. Explore share transportation options
4. Promote parenting skills workshops
5. Build community through support groups
6. Training for professionals, especially cross-disciplinary communication
7. Respite child care
8. Infant child care
9. Clean and modern parks
10. Job training

These recommendations are incorporated into the strategies found in Appendix 3 and Part VI.

INPUT FROM THE COMMUNITY CONVERSATIONS

The following summary from the ten community conversations comes from a summary report of the San Francisco Children and Families Commission's Executive Director presented at the Public Hearing of May 30, 2000. This summary, developed by the Executive Director and the Coordinator of the Civic Engagement Project, presented an overview of the themes heard at all ten conversations.

Participants in the community conversations agreed and affirmed the Focus Areas and Priorities addressed in this Strategic Plan. The universally desired result was a San Francisco that is child and family friendly, with more integrated and community-based opportunities for children and families to be supported and build connections.

The participants in the community conversations highlighted the following:

- Concern about child care, including availability (especially for infant/toddler care and flexible

care), lack of subsidies or sliding fees for working parents, quality and compensation, and ongoing provider training and education;

- Community-based parent education support, including the need for real information;
- Need for increased mental health prevention services and training and consultation for providers;
- Dental care, including a need for education and increased access to low-cost care;
- Stress of middle and low income working families who are finding it increasingly difficult to afford living in San Francisco;
- Stress of all working parents who would like more quality time with their children; and
- A deep desire to make San Francisco a more child and family friendly city.

The participants also offered some guidance concerning strategies to be funded to meet their needs:

- Create parent-friendly spaces, where parents have the opportunity to meet and talk, exchange knowledge, break isolation and create community;
- Create multi-service centers, the "one stop shop," that reflects parents' lack of time to find and travel to all they need;
- Ensure cultural and linguistic appropriateness;
- Fund family support ideas that are fun, innovative and non-traditional;
- Advocate for affordable housing and decent jobs;
- Address San Francisco's becoming unaffordable for working families;
- Involve business in solutions to problems of children and families;
- Link Proposition10 funding and programs to the same for older children, especially concerning child care and after school care and family support: families don't come in neat packages containing only the very young.

Integrating Services and Supports for Children 0-5 and their Families and Caregivers

Based on this Community Assessment, the San Francisco Children and Families Commission's obligation under the Act is to document how "programs, services and projects…within the county will be integrated into a consumer-oriented and easily accessible system."[153] The San Francisco Children and Families Commission's first response to this challenge and opportunity follows in Part V. Part V contains an overview of an "accountability framework," as detailed in Appendix 3, that enabled the Strategic Plan Advisory Committee of the San Francisco Children and Families Commission to identify a preliminary set of priorities and recommendations put out for public comment in the "Community Discussion Draft" of the Strategic Plan.[154] Based on public comment and review, the San Francisco Children and Families Commission's developed final recommendations and next steps presented in Part VI.

PART V. ACCOUNTABILITY FRAMEWORK: COMMISSION RESPONSE TO COMMUNITY ASSESSMENT

Overview

The Children and Families Act requires that the county-level strategic plans fill in a hierarchy of planning concepts to make clear what the investments by the commissions are intended to accomplish and how the commissions will know whether their intentions have been fulfilled. This hierarchy is termed the "outcome-based accountability framework" by the State Commission. The concepts that comprise the Accountability Framework include:

These concepts, or components of the Accountability Framework, may be defined as follows:

Outcomes[155] → **Objectives** → **Strategies** → **Indicators**

Outcome: A desired change in the target population over time which can be attributed to interventions supported by the San Francisco Children and Families Commission investments.
Answers the question: What do we want for children and their families in San Francisco?
EXAMPLE: Health disparities among racial/ethnic newborns are no longer significant.

Objective: A target that sets direction, magnitude and timing for interventions to achieve a desired outcome.
Answers the question: What specifically should we do for children and their families?
EXAMPLE: Congenital anomalies in newborns decline by 50% by 2003.

Strategy: An action that will accomplish one or more objectives.
Answers the question: What can we do to reach an outcome or objective?
EXAMPLE: Folic acid to prevent congenital anomalies at birth is taken by all during pregnancy.

Indicator: A numerical measure that quantifies implementation of a strategy and progress towards outcomes and objectives.
Answers the question: How are we doing?
EXAMPLE: Folic acid intake by women in prenatal care will be 95 percent by 2003.

It should be clear from this description that the Accountability Framework requires that the San Francisco Children and Families Commission engage in a continual process of planning, evaluation and planning:

Planning cycle → Outcomes, Objectives, Strategies and Indicators
↓
Evaluation cycle → Indicator data are collected and analyzed for effect on outcomes
↓
Planning cycle → Outcomes, Objectives, Strategies and Indicators revised as needed

The Accountability Framework in Appendix 3 shows the San Francisco Children and Families Commission adds some refinements to these concepts as follows:

Target population: The people whose lives should change if a desired outcome is achieved. This is where planning starts: whose lives do we hope to change for the better?

Strategic outcomes: Emphasizes that the outcomes are intended to improve health and development of children and their families, not just to change programs or policies.

Short-term Objectives: Sets an expectation concerning timing to reach objectives, in this case 1-3 years.

Strategies/investment opportunities: Underlines that any strategy should be viewed and funded as an investment with measurable payoff.

Evaluation indicators: A reminder that the purpose of indicators is to provide the basis for evaluation of the effects of investments by the San Francisco Children and Families Commission.

For this Initial Strategic Plan of the San Francisco Children and Families Commission, a first attempt at developing a comprehensive Accountability Framework for children 0-5 and their families was undertaken by the Strategic Plan Advisory Committee, with expert assistance from the consultant. A wide range of material was used to develop the framework, including information on best practices; previous work completed by Starting Points and various child care and other health and development planning efforts previously noted; and response from the Civic Engagement and public input processes of the Commission. This framework, Appendix 3 of this plan, provided the Commission and its Strategic Plan Advisory Committee the opportunity to review and evaluate an array of possibilities for the first year of planning and implementation of Proposition 10 in San Francisco.

After a careful and extensive review, a group of recommendations were selected that build on existing efforts already underway in San Francisco; provide opportunities for linkages and collaboration across and within systems and communities; and, most importantly, reflect the Commission's commitment to funding efforts that are innovative, family and community defined, and respectful of San Francisco's tremendous diversity.

PART VI. RECOMMENDATIONS AND NEXT STEPS

Recommendations

OPPORTUNITIES FOR BUILDING COLLABORATION

From Day One, prenatal to five years, young children and their families should thrive and have abundant opportunities to be healthy, grow and learn. To accomplish this vision, collaboration must become more than a word – it must become what, at its heart, it is – no more and no less than creating community in its deepest sense. It is the Commission's intent that strategies funded through Proposition 10 will integrate and coordinate services, supports and activities so that families, providers, agencies and communities may come together to provide great beginnings for San Francisco's children. The Commission believes that through weaving together existing services, funding new and innovative strategies, developing policy and promoting system change, San Francisco will approach the real collaboration that will make a difference for families and their young children.

To do this, the Commission has determined that its work will be built upon the informal and formal platforms that reflect the lives of children 0-5 and their families and caregivers. These platforms are not a program or a service; rather they are the places and opportunities to imbue the philosophy, values, and capabilities that will result in achieving a collaborative approach to supporting San Francisco's young children 0-5 and their families and addressing whatever is most meaningful for them. These places and opportunities include:

- **Where Parents Prepare for Birth or a New Child:** with relatives and friends, at health care settings, with medical providers, at private and public adoption agencies, at birth classes, at pre-adoption classes, in mothers groups, through breastfeeding and lactation support
- **Where Children are Born:** in the hospital, at home
- Where Children and Families Live: at home, with relatives, with friends, at shelters, in foster care, in institutions, in the hospital, on the streets
- **Where Children Play and Learn:** with family and friends, at child care and preschool, in playgroups, at playgrounds and parks, in libraries and schools, in neighborhoods
- **Where Families Go:** to friends and relatives, to the store and the laundromat, to places of faith and worship, to coffee shops and restaurants, to family resource centers, to social clubs and community centers, to parks, to museums and zoos, to the movies
- **Where Children and Families Get Services:** the health care system, the legal system, at immigrant services, at housing and tenant services, through public and community-based agencies
- **Where Families Receive Information and Support:** from relatives and friends, from the media (television, radio, small and large newspapers, signs on Muni and BART), from pediatricians and other medical professionals, from midwives, from the faith community, at parent support and education forums, from early childhood and family support service providers

The following recommendations of the San Francisco Children and Families Commission for its initial strategic plan will be provided through these platforms. The Commission, through its staff and other activities, will support the development of collaborative efforts based on these platforms, with the overall goal of improving access to the needed information, support, and services that will result in children flourishing in supportive, nurturing and loving families and communities.

Recommendations by Focus Areas

The following recommendations reflect the thoughtful and committed work of everyone involved with planning for the implementation of Proposition 10 in San Francisco. To the extent possible in this first year of the Commission's work, the recommendations voice the concerns and interests of the families of young children in San Francisco. The recommendations are organized by the three major focus areas of Proposition 10, Early Care and Education (Child Development), Child (and Family) Health, and Family Support and Parent Education. In addition, a fourth focus area, Children and Families Needing Enhanced Services, has been added. Possible evaluation indicators have been developed in each of the four focus areas (see Appendix 3), and will be refined during the next steps to implement the Strategic Plan. This work will take place in conjunction with the development of a comprehensive evaluation process.

FOCUS AREA: EARLY CARE AND EDUCATION (CHILD DEVELOPMENT)

Strategic Outcomes

- A full array of parent-friendly child care options is available where people live and work
- The child care sector has an adequate, stable and well-trained work force to promote high quality of care
- Child care workers have access to high quality training, conveniently located, in multiple languages
- All child care programs meet high quality standards, including operation in safe and healthy environments for children

Short-term Objectives

- Improve child care provider compensation and quality
- Increase capacity for infant/toddler child care and respite child care

Strategies/Investment Opportunities

- Create, support, expand, and monitor strategies to increase compensation and benefits for child care providers, including the Compensation and Retention Encourages Stability (CARES) Initiative.
- Increase the number of infant/toddler child care spaces through operational support for existing and new child care centers and family child care providers. Tie this support to efforts to improve quality.
- Support coordinated, high quality training and quality improvement, including incentives and credits, for licensed and license-exempt child care providers. Foster skills that help prepare children for continued learning in school.
- Create a subsidy fund to establish and pay for respite care, including care for children with special health care needs and their siblings, children who are mildly ill, and emergency back-up.
- Build capacity through technical and peer support for child care providers and parents who use child care in order to strengthen the field and develop additional strategies to address the infrastructure issues in the field, such as wages and benefits, capacity, affordability, accessibility and quality.

FOCUS AREA: CHILD (AND FAMILY) HEALTH

Strategic Outcomes

- Every child has a medical home and receives optimal and family-centered nutrition, well-baby/child health care including dental care, mental health, intellectual stimulation, emotional support and early identification and intervention of any health or developmental problems

- Disparities in child health outcomes by race/ethnicity are explicitly addressed and decreased
- Every child born to a San Francisco resident is free of preventable health and developmental problems

Short-term Objectives
- Increase coordinated, integrated and community-based strategies designed to address family-centered child health needs
- Design and tailor strategies to address and decrease health outcome disparities

Strategies/Investment Opportunities
- Expand, to address the unmet need, mental health consultation to staff at child care centers, family child care and license-exempt child care providers, staff at family resource centers, shelters, treatment programs, etc. Consultation may also include clinical services. Provide linkages with child health clinics and the medical home.
- Develop a pilot to coordinate health, mental, dental and social services, with an emphasis on early identification, assessment and intervention and addressing coordination and follow-along at the point of transition into kindergarten. Models may include neighborhood-based multi-agency teams, integrated information sharing, and ways to enhance kindergarten readiness.
- Develop a pilot to enrich pediatric care through family-centered, multi-disciplinary primary care teams with particular emphasis on expanding opportunities for developmental screening, assessment and services. Create linkages with child care and family resource and support settings.
- Support the development and integration of anti-tobacco policies and community-based tobacco cessation programs for pregnant and parenting women and their partners and coordinate programs with existing early childhood and family support services and programs.

FOCUS AREA: FAMILY SUPPORT AND PARENT EDUCATION

Strategic Outcomes
- Families have the opportunity for support, education and information that nurtures and encourages parenting conducive to the optimal health and development of children
- Parents, caregivers and community members have opportunities to create parent-friendly, family and child-centered, culturally and linguistically appropriate spaces and activities that build community, expand knowledge, increase resiliency and deepen wisdom and joy

Short-term Objectives
- Improve easy access to real information
- Increase and coordinate a wide range of family support and parent education opportunities that reflect the needs of diverse families and communities

Strategies/Investment Opportunities
- Support family resource centers as a point of triage to provide linked, standardized, and centralized services and supports tailored to the needs of diverse families. Services and supports may include peer groups and supports; parent education; information and referral; training and education for families and providers; and home visiting strategies.
- Develop and link a variety of peer-based parent/caregiver support groups, community activities and educational opportunities that are reflective of San Francisco's diversity and provided in a variety of settings
- Promote parent-initiated/community-based support strategies that are designed, organized and implemented by parents/caregivers to meet their own identified needs.

- Explore ways to centralize or coordinate existing sources of information and referral and to ensure the provision of reliable information.
- Develop a multi-lingual, multi-cultural information campaign to educate parents about children's health and development and resources for children 0-5 and their families.
- Coordinate current pre- and post-natal home visiting programs, and develop home visiting pilot(s) for outreach to families. Link home visiting efforts to the child's medical home and other services and supports for the child and family.

FOCUS AREA: CHILDREN AND FAMILIES NEEDING ENHANCED SERVICES

Strategic Outcomes

- Children and families needing enhanced services will be supported from the prenatal period through birth to age five with coordinated, family-centered services and supports tailored to overcome risks and to enhance child, parental, family and environmental strengths and resiliency

Short-term Objectives

- Increase coordinated services and supports for children and their families who are homeless
- Support interagency, parent-professional collaboration to support and serve children with special health care needs and their families

Strategies/Investment Opportunities

Children and their Families who are Homeless:

- Provide comprehensive health and mental health services in shelters and where families and children are, including domestic violence shelters and treatment programs and link child care centers to shelters for provision of needed child care.
- Provide coordinated, centralized, and collaborative referral and access to crisis mental health, housing, jobs and other resources, including centralized access to shelters for pregnant women and families.

Children with Special Health Care Needs and their Families:

- Provide interagency training, development of coordination and collaboration, and other activities to increase the early identification of and effective service delivery to children with special health care needs and their families. .

ACTIVITIES TO PROMOTE MORE EFFECTIVE EARLY CHILDHOOD POLICIES AND PRACTICES

In addition to the above recommended investment strategies, the San Francisco Children and Families Commission will allocate resources, not necessarily financial, to promote change in local, state and federal policy and practice which would contribute to optimizing the health and development of children 0-5 and their families. Such issues include but are not limited to:

- Compensation to child care providers, especially providers of infant care, that reflects the cost of doing business in San Francisco (also recommended as a funded strategy).
- Transportation options that accommodate working parents, parents with more than one child, and other family situations that call for flexible transportation.
- Universal health care coverage for children 0-5 and their families, including family planning and prenatal care and services for children with special health and developmental needs.
- Universal child care for all families who want the service, regardless of income.
- Increased capacity for developmental assessments and universal, comprehensive and periodic screening through Child Health and Disability Prevention (CHDP).

- Linkages among San Francisco city/county departments serving children and their families to ensure parent education in preventable diseases and conditions and action by appropriate agencies when environmental risks can be reduced.
- Insurance coverage of pre- and post-natal home visiting
- Safe, accessible and beautiful neighborhoods and child care facilities, including playgrounds.
- Affordable and transitional housing, for example through a master lease apartment program.
- Substance abuse treatment programs that accommodate parents and children.
- Employer support and promotion of family-friendly employee policies and practices and business support for the work of the Commission
- Inter-agency and multi-disciplinary collaboration, training, integrated funding streams, uniform and linked eligibility criteria and procedures, and coordinated data systems.

Next Steps

The Commission established a short-term Ad Hoc Committee on Infrastructure to develop next steps to implement the Strategic Plan. The following are the recommendations from the Committee, approved by the full Commission.

PROGRAM ADMINISTRATION

Administrative Structure:

The Commission has been established, by City Ordinance, as a City Department. Over the next year, staff will complete a cost-benefit analysis to determine if this is the most viable structure for the Commission's long-term work.

MOU with DCYF

The existing Ordinance states that DCYF will provide office space, administrative support and other services as specified in an MOU. DCYF and Commission administrative staff have agreed to finalize an MOU based on implementation requirements of the Strategic Plan.

- Based on available space, remain co-housed with DCYF, and determine through an MOU approved by the Commission the most cost-effective ways to independently and jointly staff and support the effort. If co-location becomes impossible due to space issues, determine what joint administrative efforts with DCYF can continue.

Staffing

- The Commission's Executive Director will determine staffing needs, at the direction of the Commission.
- The following core staff functions are anticipated, to be filled by staff positions, joint staff positions with DCYF or other entities, consultants or purchased services:
  * Executive Director
  * Executive Assistant
  * Deputy Director
  * Administration/Operations, e.g. Human Resources, Payroll, etc.
  * Finance/Accounting
  * Contracts Management
  * Program Development/Strategic Planning
  * Civic Engagement partnership with Starting Points
  * MIS Development
  * Evaluation

* Communications/Outreach
* Training/Technical Assistance/Capacity Building

PROCEDURES FOR ALLOCATING FUNDS:

- Develop and utilize an RFP process, with the possibility of also doing contracts with DPH, DHS or DCYF.
- The Commission will approve the key concepts/language for RFPs. The RFP will include criteria and desired outcomes based on the Strategic Plan.
- RFP review panels will include citizens, including outside "experts" (defined broadly), and will be trained regarding the desired criteria and outcomes.
- The Executive Director or designee will direct and witness the RFP review process.
- The Executive Director will bring a report on recommendations for funding to the Commission (based on review and ranking).
- The Commission's consideration and vote on the recommendations will serve as the immediate Appeal Process.
- MIS/Outcomes tracking based on agreed upon program and fiscal indicators, along with evaluation, will serve as the way to maintain integrity and follow-up of all funds disbursed.

PROGRAM SUSTAINABILITY

- Release the funds over time
- Explore all options for maximizing revenue from local, state and federal sources.
- Explore with the City Attorney's Office the highest yield way to invest the Trust, based on the State Attorney General's ruling that investment strategies can be determined at the local level.

Immediate Next Steps

The Commission will take the following immediate next steps to implement the approved Strategic Plan:

1. Implement the Staffing Recommendations (see above)
2. Develop and implement a Workplan including the allocations process, budget, and staffing as described above.
3. Develop an evaluation plan, including evaluation indicators and related MIS
4. Continue the Civic Engagement Project Partnership with Starting Points to ensure ongoing civic participation in the next steps of the Commission, including parent and family input into program development and outreach and education activities
5. Continue the Strategic Plan Advisory Committee to provide ongoing assistance to the Commission in the areas of program development, evaluation, best practices, policy development and related activities

Appendices

Footnotes

1 Communication Sciences Group, "Proposition 10 Civic Engagement Survey-San Francisco County-A Report Submitted to the Civic Engagement Project," February 2000.

2 Polaris Research & Development, "San Francisco Proposition 10 Commission-Community Engagement Focus Groups-Final Report" (draft) March 24, 2000.

3 Starting Points Initiative, "Proposal" for Civic Engagement funding, 1999.

4 California Health & Welfare Code Sections 130100-13155, 1999.

5 California Children and Families Commission. *Guidelines: A Resource for Developing Prop.10 Strategic Plans.* Sacramento, 1999.

6 J. Pawl in Coleman Advocates for Children and Youth, *San Francisco's Budget for Young Children 1999-2000,* 1999. (Hereafter: Coleman)

7 M.Barinaga, "New Insights into How Babies Learn Language," *Science* 277:641, 1 August 1997.

8 Ibid.

9 R.Shore, *Rethinking the Brain: New Insights into Early Development.* New York: Families and Work Institute. 1997.

10 D.Liu et al, "Maternal Care, Hippocampal Glucocorticoid Receptors, and Hypothalamic-Pituitary-Adrenal Responses to Stress," *Science* 277:1659-1662, 12 September 1997.

11 N. Scrimshaw, "The Relation between Fetal Malnutrition and Chronic Disease in Later Life," *British Medical Journal* 315:825-826, 4 October 1997. D. Barker, "Fetal Nutrition and Cardiovascular Disease in Later Life," *British Medical Bulletin* 53:96-108, 1997 and ____, "Rise and Fall of Western Diseases," *Nature* 338:371-372, 30 March 1989.

12 H. Kitzman et al, "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing," *JAMA* 278:644-652, August 27, 1997; D. Olds, "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect," *ibid.,* 637-643. Effectiveness of less rigorously designed and managed programs is uneven. See D. Gomby et al, "Long-Term Outcomes of Early Childhood Programs: Analysis and Recommendations," *The Future of Children 5* (entire issue), Winter 1995, p.8-9. (Hereafter: *The Future of Children*).

13 S. Barnett, "Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes," *The Future of Children* 5:25-49, p.25.

14 Children Now. *Right Time Right Place.* Oakland: June 1998, p.15-43.

15 C.Hertzman and M. Wiens, "Child Development and Long-Term Outcomes: A Population Health Perspective and Summary of Successful Interventions," *Social Science and Medicine* 43:1083-1095, 1996. p.1092.

16 Communication Sciences Group, *op.cit.,* Question 12.

17 See San Francisco Starting Points Initiative, "A Landscape of Early Childhood Planning and Legislation in San Francisco," 1998, for a recent list of players and programs. (Hereafter: Landscape)

18 San Francisco Starting Points Initiative, leaflet, nd.

19 San Francisco Starting Points Initiative, "Getting Children Ready to Learn: A Strategic Plan for the Emotional and Physical Health of Young Children," draft, 11/11/99 and draft, 2/9/00.

20 San Francisco Starting Points Initiative, "Getting Children Ready to Learn: A Strategic Plan for the Emotional and Physical Health of Young Children," draft, 2/9/00.

21 Coleman Advocates for Children and Youth. *San Francisco's Budget for Young Children 1999-2000.* San Francisco, 1999.

22 Ibid., p.4.

23 Ibid., p.5

24 Ibid., pp.1,4.

25 Personal communication to the consultant, April 2000.

26Ascent Associates, "San Francisco Child Care Planning and Advisory Council - Needs Assessment/Data Analysis," September, 1999.

27 Landscape, p.20.

28 San Francisco Department of Children, Youth and Their Families, *2000-2002 Children's Services Plan: An Outcomes-Based Planning Framework,*1999, p.28.

29 Ibid., p.i.

30 Ibid., p.5.

31 San Francisco Department of Public Health. *The Health and Well-Being of Children and Youth in San Francisco.* November 1998, p.8. (Hereafter: DPH)

32 Ibid., pp.154-158.

33 Personal communication to the consultant, CMHB, March 2000.

34 Family and Children's Services, "Newsbrief," January 2000 and "The Family Assessment Center" (packet), San Francisco Department of Human Services, 2000.

35 Personal communication to the consultant, San Francisco Health Plan, Director of Data Management, April 2000.

36 Unless otherwise noted, statistics in Part IV are from San Francisco Starting Points Initiative, " First Steps: Data Report on San Francisco Children Ages 0-5," February 9, 2000 (draft) and final. (Hereafter: Data Report)

37 D. Reed. *Indicator Data Report for San Francisco SB 697 Community Needs Assessment.* Northern California Community Services Council, Inc., 1996. Note that the base statistic is a census number; the 1998 number is a state projection.

38 DPH, Appendix.

39 Data Report, p.30.

40 Reed, *op.cit.,* p.II-2.

41 Ibid., p.II-8.

42 Ibid.

43 Data Report, p.59.

44 DPH, p.110.

45 Data Report, p. 21 and San Francisco Department of Human Services, May 2000 Foster Care and Emergency Assistance Quarterly Report.

46 California Department of Health Services. *Health Data Summaries for California Counties,* 1992. Sacramento,

47 SF birth rate is 12.0, California's 17.4; SF's fertility rate is 49.8, CA's 79.4. DPH, p.32.

48 California Department of Health Services, *Health Data Summaries for California Counties,* 1998. Sacramento, 1999. This statistic is missing from DPH, op. cit.

49 U. S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition) Washington DC: January 2000. P. 16-12. (Hereafter: *Healthy People 2010*)

50 Includes very low (<1,500 grams) birth weight deliveries.

51 *Healthy People 2010,* p.16-33.

52 Ibid., p.16-13.

53 DPH, Appendix table, no #. This gender disparity in infant deaths (unbiased by infanticide, usually of girls) is a world-wide phenomenon whose biology is not understood.

54 Ibid., p.43.

55 *Healthy People 2010,* p.16-19.

56 Ibid.,, Appendix table, no #.

57 All statistics in this paragraph from DPH, pp.51-99 unless otherwise noted.

58 California Department of Health Services, *Health Data Summaries for California Counties,* 1998, Sacramento, 1999.

59 Consistent with current federal and state health policy, mental health is included in this Plan in parity with physical health. Many mental health concerns also fit under "developmental status."

60 S-L. Chan-Sew, "Presentation for San Francisco Children and Families Commission - Mental Health Services for the Zero to Five," March 2000.

61 R. Mishra, "Surgeon General Assails Unequal Dental Care in U.S.," *San Francisco Chronicle,* May 26, 2000, p.3.

62 Personal communication to the consultant, F. Ramos-Gomez, May 2000. Dr. Ramos-Gomez, Division of Pediatric Dentistry, University of California- San Francisco, performed the study in 1999.

63 Ibid.

64 The state Department of Health Services estimated in 1989 that 5-10 percent of newborns have disabilities and an additional 10-17 percent are at risk for developmental delay. These numbers vary with prenatal and neonatal care, which have changed significantly. Cited in: Mayor's Office of Children, Youth, and Their Families, "A Briefing Paper for the San Francisco Children and Youth Summit," October 1996, p.13.

65 Data Report, .24.

66 DPH, p.149.

67 DPH, p.151.

68 Data Report, p.25.

69 "Unprepared" is defined as: poor health, unable to count to 10, and unable to recite the alphabet. A. McQueen, "Most Kids Well Prepared at Start of Kindergarten," *San Francisco Chronicle,* February 18, 2000

70 Ibid.

71 R. Williams, "Lower Socioeconomic Status and Increased Mortality: Early Childhood Roots and the Potential for Successful Interventions," *JAMA,* 279:1745-1746, June 3, a998. See also: R. Evans, M. Barer, and T. Marmor. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* New York: Aldine de Gruyter. 1994. I. Kawachi, B. Kennedy and R. Wilkinson. "The Society and Population Health Reader: Income Inequality and Health," Robert Wood Johnson Foundation *Author Series* Vol.2 #1, November 1999.

72 Reed, p.II-8.

73 DPH, p.101.

74 D.Williams, "How Income, Race and Other Factors Influence Health - Papers and Publications," Robert Wood Johnson Foundation *Author Series* Vol.1 #4, September 1998.

75 "President Clinton Announces New Racial and Ethnic Health Disparities Initiative," press release, February 21, 1998.

76 D. Smith, "Health Care Divided: Race and Healing a Nation," Robert Wood Johnson Foundation *Author Series* Vol.1 #8, February 1999.

77 This disparity has been known for decades and is a nationwide phenomenon. While rates of very low and low birth weight have declined enormously among all groups since 1960, the disparity persists.

78 DPH, p.60.

79 Ibid., p.150.

80 Ibid., Appendix table, no #.

81 Ibid., p.102.

82 Data Report, p.38.

83 Reed, *op.cit.,* p.III-88.

84 DPH, p.57.

85 Reed, *op.cit.,* p.IV-21.

86 Ibid., p.IV-22.

87 Ibid., p.IV-23.

88 A new agency funded by the Robert Wood Johnson Foundation, the Collaborative Center for Child Well-being in Atlanta, intends to "promote a strengths-based approach to child health and development." The Collaborative Center for Child Well-being, "Update," Vol.1 #1, December 1999.

89 L. Berkman and I. Kawachi. *Social Epidemiology.* New York: Oxford University Press. 2000.

90 An example of a successful study of community efficacy is R.Sampson, S. Raudenbush, F.Earls, "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy," *Science* 277:918-924, 1997.

91 Evans, *op.cit.* and Kawachi, *op.cit.*

92 For one proposed approach to housing issues, see The People's Budget Collaborative, "Preservation and Creation of Affordable Housing and Homelessness Prevention Fund," San Francisco, 2000.

93 "Medical home" refers to the place and provider providing continuous care to a child (or anyone else). Children with a medical home are more likely to access needed services than children without.

94 Personal communication to the consultant, March 2000. San Francisco is one of several counties for which samples will be large enough for county-level analysis.

95 California Department of Health Services, *Health Data Summaries for California Counties,* 1996, Sacramento, 1996, p.153.

96 DPH, p.146.

97 Mayor's Blue Ribbon Committee on Universal Health Care. *Achieving Health Insurance for San Francisco's Uninsured.* San Francisco, 1998.

98 For a description of the child care sector in California, see K. Karpilow. *Understanding Child Care: A Primer for Policy Makers.* Sacramento, CA:Institute for Research on Women and Families, 1999.

99 These numbers come from Ascent Associates, "San Francisco Child Care Planning and Advisory Council - Needs Assessment/Data Analysis," September, 1999, "Capacity information" table (no # or page #) as interpreted for the consultant by M. Rutherford, April 2000. The total approximates the 13,300 estimate in California Child Care Resource & Referral Network, "The 1999 California Child Care Portfolio-San Francisco County," p.2, where the estimate includes slots for children up to six years. Exact numbers should be considered subject to change but the order of magnitude is believed accurate.

100 Calculations by the author: 53,932 estimated children 0-5 ÷ 13,650 spaces; 13,659 spaces÷ [53,923÷1,000 children].

101 *The Carolina Abecedarian Study.* University of North Carolina: Frank Porter Graham Child Development Center, 1999.

102 Family Resource Coalition, *Guidelines for Family Support Practice,* Chicago, 1996, p.2.

103 Ibid., p.1 and A. Rassen, "Family Support," Family Resource Coalition of America, Chicago, 2/2/00.

104 Family and Children's Services Division, "An Overview of Family Preservation and Family Support Services Supported by San Francisco Department of Human Services," San Francisco Department of Human Services, 1/23/00.

105 California Interagency Coordinating Council, *Family Support Guidelines for Effective Practice,* Resources in Special Education, 1995.

106 Starting Points Initiative, "An Overview of the Members of the Family Resource Center Consortium of San Francisco," 1/28/98.

107 The Family Resource Center Consortium of San Francisco, "Overview and Agency Profiles," January 1999.

108 A. Rassen, "Family Support for Everyone: A Proposition 10 Opportunity," Family Support California, nd.

109 Family Focused Care Committee, "Family Focused Care," Children's System of Care Planning Council, Division of Mental Health, Department of Public Health, 1999.

110 Data Report, p.41. Improvement in the rate was mentioned by members of the Strategic Planning Committee at its meeting of March 8, 2000.

111 DPH, p.106.

112 Healthy Children Organizing Project, miscellaneous materials, March 2000.

113 Personal communication to the consultant from a member of the public attending a SPC meeting, March 2000.

114 Personal communication to the consultant from M. Rutherford, DHS, March 2000.

115 The San Francisco Children and Families Commission Strategic Plan Committee, sub-group on child care strategies, April 2000.

116 From the CCPAC Needs Assessment Committee via personal communication to the consultant from M. Rutherford, April 18, 2000.

117 Ibid.

118 Personal communication to the consultant from M. Rutherford, DHS, March 2000.

119 Coleman, *op.cit.,* p.22 and Landscape, p.7.

120 Personal communication to the consultant from M. Rutherford, DHS, April 2000.

121 Starting Points Initiative, "First Steps-Children 0-5 in San Francisco-A Data Report on the Status of San Francisco's Young Children," April 2000, p.17 (draft).

122 Ibid.

123 Personal communication to the consultant from M. Rutherford, DHS, March 2000. DHS is pledged to seeking out and assisting welfare-to-work mothers eligible for child care subsidies.

124 Personal communication to the consultant from M. Rutherford, DHS, March 2000.

125 Personal communication to the consultant from M. Rutherford, DHS, March 2000.

126 San Francisco Department of Children, Youth and Their Families, *2000-2002 Children's Services Plan: An Outcomes-Based Planning Framework,* 1999, p.16.

127 Coleman, *op. cit.,* p.23, ibid., p.16, and Landscape, p.33.

128 Studies cited in Starting Points Initiative, "First Steps-Children 0-5 in San Francisco-A Data Report on the Status of San Francisco's Young Children," April 2000, p.18 (draft).

129 Department of Public Health, "Summary of Survey of Licensed Family Child Care Providers in San Francisco Regarding Health Issues of Children in Their Care," 1999.

130 Personal communication to the consultant from S-L. Chan-Sew, March 2000.

131 Coleman, *op.cit.* p.18.

132 Ibid., p.22.

133 Presentation by L. Tanner, MD, Director of the Division, to the Strategic Planning Committee, March 15, 2000.

134 DPH, p.155.

135 *Healthy People 2010,* p.16-27.

136 C. Mustard and N. Roos, "The Relationship of Prenatal Care and Pregnancy Complications to Birthweight in Winnipeg, Canada," *American Journal of Public Health* 84:206-213, September 1984; W. Ray, "Effect of Medicaid Expansion on Preterm Birth," *American Journal of Preventive Medicine* 13:292-297, 1997, cited in *JAMA* 278:1044, October 1, 1997.

137 Data Report, pp., 13.

138 DPH, p. 64.

139 C.Yap, DCYF, Letter and attachments concerning Safe Start grant application to US Department of Justice, December 16, 1999.

140 C. Hall, "Doctors Urged to Focus on Preventing Child Violence," *San Francisco Chronicle,* March 7, 2000, p.1 and personal communication to the consultant, April 2000.

141 Chan-Sew, p.1.

142 DPH, p.144-145.

143 Mayor's Blue Ribbon Committee, *op.cit.,* p.vii.

144 Personal communication to the consultant, April 2000.

145 Starting Points Initiative, "Home Visiting Programs in San Francisco," Department of Children, Youth and Their Families, 1999, p.3. Effectiveness of home visiting programs has been demonstrated by both random trails and observational studies. Critical according to the randomized trials is the design of the program. D. Olds, "Prenatal and Early Childhood Nurse Home Visitation Programs, " presentation at "Home Visitation Programs and Family Resource Centers, " Los Angeles Departments of Health Services and Mental Health et al, January 20, 2000.

146 A. Galbraith, "Universal Newborn Home Visiting in San Francisco - A Proposal for a Program Using Prop.10 Funds," 1999.

147 Strategic Planning Committee of the Commission on Children and Families, meeting of March 8, 2000.

148 DPH, p.57-60.

149 Polaris Research and Development, *op.cit.*

150 Polaris notes: "It was often surprising how participants openly discussed this issue." P.6.

151 Ibid., p.5.

152Ibid., p.10-12.

153California Health and Safety Code Section 130140(1)(C)(ii).

154 San Francisco Commission on Children and Families, *Initial Strategic Plan - Community Discussion Draft,* May 1, 2000, Executive Summary pp.E-5-E9.

155 Also termed "results." J. Henderson, "Draft Results," California Children and Families Commission, February 11, 2000.

References

A. Galbraith, "Universal Newborn Home Visiting in San Francisco - A Proposal for a Program Using Prop.10 Funds," 1999.

A. Rassen, "Family Support for Everyone: A Proposition 10 Opportunity," Family Support California, nd.

A. Rassen, "Family Support," Family Resource Coalition of America, Chicago, 2/2/00.

Alameda County Children and Families Commission. *Every Child Counts - Strategic Plan.* December, 1999.

Alameda County Children and Families Commission, "Outcome Indicators for Alameda County Every Child Counts Project," 7/21/99.

Ascent Associates, "San Francisco Child Care Planning and Advisory Council - Needs Assessment/Data Analysis," September, 1999.

C.Hertzman and M. Wiens, "Child Development and Long-Term Outcomes: A Population Health Perspective and Summary of Successful Interventions," *Social Science and Medicine* 43:1083-1095, 1996.

C.Yap, Department of Children, Youth and Their Families, Letter and attachments concerning Safe Start grant application to US Department of Justice, December 16, 1999.

California Child Care Resource & Referral Network, "The 1999 California Child Care Portfolio-San Francisco County," 1999.

California Children and Families Commission. *Guidelines: A Resource for Developing Prop.10 Strategic Plans.* Sacramento, CA 1999.

California Department of Health Services, *Health Data Summaries for California Counties,* 1992, Sacramento, 1993.

California Department of Health Services, *Health Data Summaries for California Counties,* 1994, Sacramento, 1994.

California Department of Health Services, *Health Data Summaries for California Counties,* 1998, Sacramento, 1999.

California Interagency Coordinating Council, *Family Support Guidelines for Effective Practice,* Resources in Special Education, 1995.

Children Now. Right Time Right Place. Oakland: June 1998.

Coleman Advocates for Children and Youth, *San Francisco's Budget for Young Children 1999-2000,* 1999.

Communication Sciences Group, "Proposition 10 Civic Engagement Survey-San Francisco County," February, 2000.

D. Gomby et al, "Long-Term Outcomes of Early Childhood Programs: Analysis and Recommendations," *The Future of Children* 5 (entire issue), Winter 1995.

D. Reed. *Indicator Data Report for San Francisco SB 697 Community Needs Assessment.* Northern California Community Services Council, Inc. San Francisco: 1996.

D.Liu et al, "Maternal Care, Hippocampal Glucocorticoid Receptors, and Hypothalamic-Pituitary-Adrenal Responses to Stress," *Science* 277:1659-1662, 12 September 1997.

D. Smith, "Health Care Divided: Race and Healing a Nation," Robert Wood Johnson Foundation *Author Series* Vol.1 #8, February 1999.

D. Williams, "How Income, Race and Other Factors Influence Health," Robert Wood Johnson Foundation *Author Series* Vol.1 #4, September 1998.

Department of Children, Youth, and Their Families, "Mayor's Children's Cabinet," March 20, 2000.

Department of Health and Human Services. *Healthy People 2010.* Washington DC: 2000

Department of Public Health, "Summary of Survey of Licensed Family Child Care Providers in San Francisco Regarding Health Issues of Children in Their Care," 1999.

Family Children's Services Division, "Newsbrief," January 2000 and "The Family Assessment Center" (packet), San Francisco Department of Human Services, 2000.

Family and Children's Services Division, "An Overview of Family Preservation and Family Support Services Supported by San Francisco Department of Human Services," San Francisco Department of Human Services, 1/23/00.

Family and Children's Services Division, "The Family Assessment Center," (folder), nd.

Family Focused Care Committee, "Family Focused Care," Children's System of Care Planning Council, Division of Mental Health, Department of Public Health, 1999.

Family Resource Coalition, *Guidelines for Family Support Practice.* Chicago: 1996.

G.Kolata, "Studying Learning in the Womb," *Science* 225:302-303, 20 July 1984.

H. Kitzman et al, "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing," *JAMA* 278:644-652, August 27, 1997; D. Olds, "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect," *The Future of Children* 5:637-643.

I.D.A. News, Infant Development Association of California, 27:1, Winter 2000.

K. Karpilow. *Understanding Child Care: A Primer for Policy Makers.* Sacramento, CA: Institute for Research on Women and Families, 1999.

M.Barinaga, "New Insights into How Babies Learn Language," *Science* 277:641, 1 August 1997.

Mayor's Office of Children, Youth and Their Families, "A Briefing Paper for the San Francisco Children and Youth Summit, October,1996.

Polaris Research & Development, "San Francisco Proposition 10 Commission-Community Engagement Focus Groups-Final Report" (draft) March 24, 2000.

R. Greenstein, "Food Security for the Poor" in S. Samuels and M. Smith, eds. *Improving the Health of the Poor.* Menlo Park CA: The Henry J. Kaiser Family Foundation, 1992.

R.Shore, *Rethinking the Brain: New Insights into Early Development.* New York: Families and Work Institute. 1997.

S. Barnett, "Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes," *The Future of Children,* 5:25-49.

San Francisco Department of Children, Youth and Their Families, "2000-2002 Children's Services Plan: An Outcomes-Based Planning Framework,"1999.

San Francisco Department of Health Services and San Francisco Unified School District, "The Health and Well-Being of San Francisco Unified School District Students K-12," 1999.

San Francisco Department of Public Health, "The Health and Well-Being of Children and Youth in San Francisco," November 1998.

San Francisco Starting Points Initiative & Mayor's Office of Children, Youth and Their Families, "A Landscape of Early Childhood Planning and Legislation in San Francisco," 1998.

San Francisco Starting Points Initiative, "An Overview of the Members of the Family Resource Center Consortium of San Francisco," 1/28/98.

San Francisco Starting Points Initiative, "Data Report on San Francisco Children Ages 0-5," February 9, 2000.

San Francisco Starting Points Initiative, "Getting Children Ready to Learn: A Strategic Plan for the Emotional and Physical Health of Young Children," draft, 11/11/99 and draft, 2/9/00.

San Francisco Starting Points Initiative, "Home Visiting Programs in San Francisco," Department of Children, Youth and Their Families, 1999.

S-L. Chan-Sew, "Presentation for San Francisco Children and Families Commission - Mental Health Services for the Zero to Five," March 2000.

S. Rosenbaum, "Improving Child Health" in S. Samuels and M. Smith, eds. *Improving the Health of the Poor.* Menlo Park CA: The Henry J. Kaiser Family Foundation, 1992.

The Family Resource Center Consortium of San Francisco, "Overview and Agency Profiles," January 1999.

W. Clinton, "New Racial and Ethnic Health Disparities Initiative," press release, February 21, 1998.

Appendix 1.

San Francisco Children and Families Commission

Virginia Smyly, Commission Chair, Deputy Director, Community Health Promotion & Prevention Branch, San Francisco Department of Public Health

Dr. Nancy Torres, Commission Vice Chair, Assistant Chief, Pediatric Department, Kaiser Permanente, San Francisco

Deborah Alvarez-Rodriguez, Director, San Francisco Department of Children, Youth and Their Families

Margaret Brodkin, Executive Director, Coleman Advocates for Youth

Frank Chong, Dean of Student Affairs, City College of San Francisco

Will Lightbourne, Director, San Francisco Department of Human Services

Dr. Cheryl Polk, Director, Miriam & Peter Haas Fund

Dr. Francisco Ramos-Gomez, Associate Professor of Pediatric Dentistry, Division of Pediatric Dentistry, University of California – San Francisco

Supervisor Mabel Teng, San Francisco Board of Supervisors

Andrea Youngdahl, Executive Director

Appendix 2.

Members of the Strategic Plan Advisory Committee and the Civic Engagement Advisory Committee of the San Francisco Children and Families Commission

Strategic Plan Advisory Committee

Deborah Alvarez-Rodriguez,* Department of Children, Youth and Their Families
Sai-Ling Chan-Sew, Department of Public Health
Karen Jones-Mason, San Francisco Women's Lawyers Alliance
Rosie Kennedy, San Francisco Family Child Care
Linnea Klee, PhD, Children's Council
Laurel Kloomok, Jewish Family and Children's Services
Patricia Mejia, Support for Families of Children with Disabilities
Sheila Norman, Candlelight Child Development Center
Cheryl Polk, PhD, Miriam and Peter Haas Fund
Michele Rutherford, Department of Human Services
April Silas, Homeless Children's Network
Lane Tanner, MD, University of California – San Francisco, Medical Center

Lucy Johns, Consultant, Health Care Planning and Policy: Primary Consultant on the development of the Strategic Plan, including compilation and analysis of data and author of the original draft.

Andrea Youngdahl, Executive Director, San Francisco Children and Families Commission

*Chair

Other Significant Participants:

Ansible Consulting
Mildred Crear, Maternal and Child Health, DPH
Patsy Davies Hampton, HRIIC
Ellen Dektar, DCYF
Jun• Duenas, Support for Families of Children with Disabilities
Tamar Dorfman, Starting Points
Neil Gendel, Consumer Action – Healthy Children Organizing Project
LaTonya Harris, Starting Points
Renu Nanda, Starting Points
Krystal Robinson, Civic Engagement Project
Carol Stevenson, Starting Points
Anna Yee, Mayor's Office for Community Development

Civic Engagement Advisory Committee

Nancy Torres*, MD, Kaiser Permanente Medical Center
Diane Cottrell, Wu Yee Children's Services
Cheryl Deaner, All Our Families Coalition
Cassandra Dobrin, California Children's Services
Jun• Duenas, Support for Families of Children with Disabilities

Jose Ramos Fernandez-Pena, Regional Health Occupations Resource Center
Patsy Jones, TALKLine Family Support Center
Alma Martinez, MD, San Francisco General Hospital Department of Pediatrics
Ida McCray, San Francisco Sheriff's Department
Heidi McLaughlin, Mission Head Start
Francisca Oropeza, Catholic Charities
Gladys Sandlin, Mission Neighborhood Health Center
Carol Stevenson, Starting Points
Maria Luz Torre, Parent Voices
Rene Velasquez, Instituto Familiar de la Raza
Rebecca Vilkomerson, Homeless Prenatal Project
Mary Beth Wallace, Coleman Advocates
Joe Wilson, Coleman Advocates
Amy Yu, Asian Perinatal Advocates
Krystal Robinson, Civic Engagement Project, Coordinator

*Chair

Other Significant Participants:

The Civic Engagement Project: Bonnie Bjerre and Susan Clark
Polaris Consulting
Mari Arreola, Language Bank and Parent
Gene Chan, Chinatown Child Development Center
Amy Chang, Fu Yau Project
Charlene Clemens, Family Services Agency
Nani Coloretti, DCYF
Anita Fong, Department of Public Health
Cathy Garza, DCYF
Fawn Gustin, Starting Points
LaTonya Harris, Starting Points
Mai-Mai Ho, Asian Perinatal Advocates
Bill Kramer, DCYF
Christina Shea, Fu Yau Project
Gloria Tan, Asian Women's Resource Center

Appendix 3.

Accountability Framework 2000-2003

STRATEGIC OUTCOME I

Every child born to a San Francisco resident is free of preventable health and developmental problems.

Target Population

All children 0-5 and their families

Short-Term Objectives

- Reduce perinatal deaths by 25% by 2003.
- Rate of low and very low birth weight babies declines to 5/1000 by 2003.
- Babies exposed to addictive substances in utero decline by 30% by 2003.

Strategies/Investment Opportunities

- Universal prenatal care that includes early toxicology screening.
- Smoking cessation education and supports, including use of peer models.
- Outreach to women on effects of substance abuse on child health and development and treatment options.
- Universal home visiting pre- and post-partum.
- Educate prenatal care providers about substance abuse and services.
- Educate prenatal providers about family support services.
- Educate major SF insurance carriers and HMOs about payment for home visiting.
- Disseminate knowledge of infant brain development and research.
- Ready access or transfer to facilities for high-risk births.
- Universal health care coverage 0-5 and their parents or caregivers.

Evaluation Indicators (numerators only)

- Perinatal deaths
- Low + very low birth weight births
- Births with symptoms of exposure to alcohol, tobacco, other drug
- C-sections by cause

STRATEGIC OUTCOME II

Every child has a medical home and receives optimal nutrition, well-baby/child health care including dental care, mental health, intellectual stimulation, emotional support, and early intervention for any health or developmental problems.

Target Population

All children 0-5 and their families

Short-Term Objectives

- Healthy mothers breast feeding to six months = 50%, at 12 months = 25%.
- Coverage for child health care, including mental, dental and developmental assessment, is 100%
  by 2005.

- Infant mortality declines by 50% by 2003.
- 100 % of children with special needs are identified early by 2003.
- Prevalence of asthma 0-5 is measured by 2002.
- Prevalence of asthma 0-5 is reduced 25% by 2005.
- Child development activities are available to promote socialization, physical activity, and learning to x% of families.
- Immunization rate by 2 years is 90% by 2003.
- Increase in coordinated, integrated and community-based strategies designed to address family-centered child health needs.

Strategies/Investment Opportunities

- Offer universal hearing screening at birth.
- Outreach to, enrollment of, and retention of families eligible for MediCal and Healthy Families.
- Train health and community-based professionals in early identification of children with special needs.
- Maintain high quality referral and training in child development.
- Train health, government (including Park&Rec) and community-based professionals in child development.
- Educate major SF insurance carriers and HMOs about financing of developmental assessment.
- Enriched pediatric care, publicly and privately funded, embedded in primary care teams, including developmental, legal, and community linkages.
- Conduct CHDP screening on all children.
- Continual surveillance and screening for health and developmental problems.
- Employer incentives and training for family-friendly policies and workplace, such as family leave, breast-feeding, and child care.
- Face-to-face teen parent education/inter-action about nutrition.
- Early dental health assessment, prevention, and treatment.
- Playgrounds that are safe, clean (especially of drug paraphernalia) wheel-chair accessible.
- Child activity programs through community centers, libraries, other neighborhood resources.
- Parent and caregiver participation at all levels of program development and implementation

Evaluation Indicators (numerators only)

- Mothers breast feeding up to 6 and 12 months
- Children with identified pediatric "medical home"
- "Medical homes" linked with dental, developmental, and mental services
- Employers with family leave policies by size of employer
- Employers with infant child care policies, including facilities
- Employers with breast-feeding policies and space
- Hearing assessments & follow-up
- Deaths 0 up to 1 year decline from about 40 to about 20 deaths per year
- Number of intentional injuries by E-code
- Number of unintentional injuries by E-code

- Immunizations completed per AAP schedule
- Morbidity surveillance, esp. for chronic Dx (asthma)
- Ambulatory-care-sensitive discharges for 0-5
- Insurance carriers and HMOs doing business in SF offer developmental assessment benefit
- Child development activities/programs by site and scope

STRATEGIC OUTCOME III

Full array of parent-friendly child care options is available near where people live and work.

Target Population

All children 0-5 and their families

Short-Term Objectives

- The number of licensed family child care spaces for infants/ toddlers increases to 1,200 by 2003.
- Recruitment, training, and retention of family child care providers for infant/toddler care in low-supply areas is established and on-going by 2001.
- Centralized eligibility system is in place by 2002.
- Parents and caregivers working non-traditional hours have access to child care by 2003.
- Parents and caregivers have access to back-up, respite, non-traditional hours, and mildly-ill child care by 2003.

Strategies/Investment Opportunities

- Financial support for child care centers to develop and run infant programs.
- Spaces for infants/toddlers increase through recruitment, training, and retention of existing family child care providers.
- Capital and technical assistance for child care centers to expand into infant care.
- Training of child care providers to relate respectfully to diverse characteristics of parents and children.
- Child care space built into affordable housing.
- Incentives for providers to offer non-traditional hours, respite, and back-up services.
- Technical assistance from DPH concerning ill-child care.
- Advocacy for state reimbursement rate for care of mildly ill.
- Improved transportation options that reflect parental schedules and multiple locations of child care for siblings of different ages.
- Collaboration between child care providers and advocates for full-day child care.
- Collaboration among family child care providers for mutual support and advocacy.
- Study of the child care sector for its contributions to the local economy.
- Child care advocacy capacity to influence federal and state policy, especially concerning wages and benefits.

Evaluation Indicators (numerators only)

- Child care slots by age and site
- Child care slots by location, hours, backup capacity
- Waiting times for preferred placement

- Waiting times for any placement
- Complaints to R&Rs by type
- Standard intake forms appear
- Use of standard intake form
- Changes in federal and state policy as sought by advocates

STRATEGIC OUTCOME IV

Child care subsidies are available, from public and private sources, for all eligible families.

Target Population

All children 0-5 and their families

Short-Term Objective

- Subsidies to families with children 0-2 increases to 75% by 2003.
- Subsidies to families with children 3-5 increases from 69% to 75% by 2003.
- Reduce subsidy eligibility list by 50% by 2003.

Strategies/Investment Opportunities

- Fully enrolled SFUSD child care programs.
- Full day, full year Head Start and state preschool programs.
- SF Labor Council and local unions negotiate child care benefits in labor contracts.
- SF business groups encourage and SF businesses provide child care benefits.
- Low-wage city employees have access to subsidized child care.
- Child care subsidies for parents as per identified need.
- Finalize a centralized eligibility list for subsidies by 2002.
- Investigate new models of child care financing using a higher education model and tax credits.

Evaluation Indicators (numerators only)

- All available subsidy funding is utilized immediately
- Families with children 0-2 with subsidies increases from current %
- Families with children 3-5 with subsidies increases from current 69%
- Child care benefits by scope in negotiated contracts
- Child care benefits by scope in non-negotiated contracts
- Subsidy funds by source and use

STRATEGIC OUTCOME V

All parents in San Francisco are educated about child health and development after birth.

Target Population

All children 0-5 and their families

Short-Term Objective

- Provide quality parenting education in Chinese, Spanish and English throughout SF by 2003.

Strategies/Investment Opportunities

- Develop teaching modules on parenting, child development and child health for middle and high school.

- Develop and offer issue-oriented workshops at accessible neighborhood sites.
- Provide information to all expectant parents and parents of newborns on child care options, family support and parent education.

Evaluation Indicators
- Parents completing training
- Parents' exposure to education by reportable events

STRATEGIC OUTCOME VI
Health, child development, and family support services provided prenatally and to children 0-5 and their families are integrated into a consumer-oriented and easily accessible system.

Target Population
All children 0-5 and their families

Short-Term Objective
- Planning for computerized linkages within and among government and private agencies begins by 2001.
- Funding for strengthening of agency management, public and private, for operations and accountability reporting, is included in rate-setting and/or grants by public and private funders by 200x.

Strategies/Investment Opportunities
- Develop single intake/eligibility form for all social services.
- Develop single intake/eligibility form for all health services.
- Coordinate those forms.
- Centralize information and referral for child care, both subsidized and non-subsidized.
- Create multi-agency intake and care management teams.
- Apply lessons from Early Childhood Assessment Information Project.
- Integrate funding and de-categorize contracting at government agencies serving children 0-5.
- Create multi-agency "hubs" at sites of existing agencies.
- Use schools as hubs.

Evaluation Indicators (numerators only)
- Tracking statistics available for:
  - outcomes of R&R services
  - children by child care experience over long periods to link with "readiness" statistics
- Waivers, etc. enabling co-mingling of government funds by family
- Cost and revenue data per family by outcome and source
- Routine consumer satisfaction survey results

STRATEGIC OUTCOME VII
Children enter kindergarten physically and mentally healthy and eager to continue to learn.

Target Population
All children 0-5 and their families

Short-Term Objective
• Number of children entering kindergarten with unmet health, mental health and dental needs or unprepared for school declines by X% per year 2001-200x.

Strategies/Investment Opportunities
• Screen children for school readiness.

• Assist transition to kindergarten.

• Develop approaches to schools being ready for the child.

• Coordinate health, mental, dental, social services with schools and families.

• Help immigrant families with transition to school.

Evaluation Indicators
• "Readiness" stats, including: health and developmental status; ability to count to 10; ability to recite alphabet; other (social skills)

STRATEGIC OUTCOME VIII
a) Families have the opportunity for support, education and information that nurtures and encourages parenting conducive to the optimal health and development of children.

b) Parents, caregivers and community members have opportunities to create parent-friendly, family and child-centered, culturally and linguistically appropriate spaces and activities that build community, expand knowledge, increase resiliency and deepen wisdom and joy.

Target Population
All parents and caregivers of children 0-5

Short-Term Objectives
• Births to mothers ≤18 decline by 50% by 2003.

• Literacy of parent/caregiver in any language ≥90% by 200x.

• Literacy in English of parent/caregiver ≥75% by 200x.

• Number of teen parents graduating from high school increases by statistically significant numbers.

• Number of parents obtaining an equivalent of a high school diploma increases by statistically significant numbers.

• Improve easy access to realy information.

• Increase and coordinate a wide range of family support and parent education opportunities that reflect the needs of diverse families and communities.

• Parent/caregiver smoking at home decreases to 0 by 2003.

• Books for children are in every home with children 0-5 by 2003.

• Parent/caregiver with excessive drinking decreases to X% by 2003.

• Parent/caregiver using illegal drugs decreases to x% by 2003.

Strategies/Investment Opportunities
• Age-appropriate and medically-accurate sex education from age x.

• Affordable, confidential contraception options for females and males.

• Emergency contraception accessible.

• Services and support for life changes during prenatal period.

- Birth gift (local version of state template) for all families of newborns.
- A single, reliable source with one phone number to answer a variety of questions from parents.
- Subsidies to attend parenting activities.
- Easily accessed, issue-oriented workshops for parents needing help with specific issues.
- Support groups for parents, especially peer groups.
- Father groups and support.
- Approaches to reaching isolated parents.
- Support for parents in high school and in college.
- Substance abuse treatment options that accommodate parents.
- Support mothers in recovery to stay home.
- Smoking cessation programs geared to parents.
- Transportation options, including a "Child Care Express."
- Family resource centers with standard services funded and staffed in diverse neighborhoods serving diverse families.
- Adult English literacy classes with child care available.
- Other language literacy classes with child care available.
- Books for children given away by health, mental health, child care, and family resource providers.
- Drop-in child care so parents can access needed services or find brief respite.
- Education and incentives for employers to recruit, train, retain parents, especially homeless parents.
- Education for professionals involved with parents about coordination of services, law, and respect for parents and caregivers.
- Explore ways to centralize or coordinate existing sources of information and referral and to ensure the provision of reliable information.
- Social marketing campaigns.
- Promote parent-initiated/community-based support strategies that are designed, organized and implemented by parents/caregivers to meet thier own identified needs.

Evaluation Indicators (numerators only)

- Births to mothers 18 and under decline from over 150 to under 90
- Births by high school completion
- Contraceptive use
- Emergency contraception use
- Pregnant women and new mothers placed in housing, training, jobs, TANF, other support systems
  previously lacking
- Parental literacy in English
- Parental literacy in any language by language
- Parental health and mental health
- Births with symptoms of exposure to alcohol, tobacco, other drugs
- Fathers present: during pregnancy; after birth; during 0-5 period
- Fathers present without addictive behaviors or violence

- Foster placements at birth
- Foster care 0-5 by age
- Foster care length of stay, transfer, and re-admits
- Mothers with positive smoking, alcohol, drugs at birth
- Mothers with positive smoking, alcohol, drugs with children 0-5 at home
- Children 0-5 abuse/neglect calls
- Children 0-5 referred to Child Protective Services
- Children exposed to violence (police reports-see below)
- Survey data for "quality time"; reading
- Hotline calls and outcomes
- Customer satisfaction with support groups
- Customer satisfaction with family support
- "Disasters averted": any way to measure?

STRATEGIC OUTCOME IX

Children 0-5 are raised in households free of or at least protected from domestic violence.

Target Population

All parents and caregivers of children 0-5

Short-Term Objectives

- Parent/caregiver with guns in the home educated about safety and using safety devices by 2002.
- Mothers seen in emergency rooms due to domestic violence injuries declines yearly.
- Children injured or killed as a result of domestic violence/abuse declines yearly.
- Calls to DHS reporting suspected child abuse decline yearly.
- Cultural acceptance of domestic violence declines.

Strategies/Investment Opportunities

- Routine, universal screening of pregnant women for domestic violence during prenatal visits.
- Pediatricians routinely screen for child exposure to domestic violence.
- Anger management and violence reduction training and counseling programs directed at parents/caregivers.
- Police routinely document names and ages of children in household during calls for domestic violence.
- Police routinely provide referrals to domestic violence and anger management programs during calls for domestic violence.
- Child 0-5 and mother play groups in battered women's shelters.
- Support groups for battered women and battering men in FRCs.
- Specialized units in DHS providing wrap-around family services.
- Routine training for child care providers to identify exposure to domestic violence.
- Mental health consultation to child care providers routinely including domestic violence component.

Evaluation Indicators (numerators only)

- Prenatal visit screening
- Pediatrician visit screening

- Police reports of violence to parents, children
- Police reports of children witnessing violence
- Police referrals
- Follow-up to police referrals
- Referrals by child care providers
- Coordinated follow-up to child care provider referrals
- Identification, referrals, and follow-up by mental health providers
- Attendance at support groups for battered and battering parents

STRATEGIC OUTCOME X

Pregnant women and parents have affordable housing.

Target Population

All parents and caregivers of children 0-5

Short-Term Objectives

- Subsidies to maintain access to rental housing in SF for very low income parents by 2001.
- Homeless pregnant women and parents access shelters and other services through a central and coordinated source.

Strategies/Investment Opportunities

- Advocacy activity concerning housing availability, cost, access.
- Homeless shelters enable access to crisis, health, mental health, job training, housing services.

Evaluation Indicators (numerators only)

- Pregnant women and parents of 0-5 living in housing by location of housing (SF, Bay Area, other state, out-of-state)
- Homeless parents by age of child, reason for homelessness, length of time homeless

STRATEGIC OUTCOME XI

Children and families needing enhanced services will be supported from the prenatal period through birth to age five with coordinated, family-centered services and supports tailored to overcome risks and to enhance child, parental, family and environmental strengths and resiliency.

Target Population

Children 0-5 and families needing enhanced services

Short-Term Objectives

- Including but not limited to the following groups of parents/caregivers, the following parental groups need enhanced services beginning in 2000:
  -<18;
  -grandparents;
  -homeless;
  -LGBT;
  -don't speak English;
  -unemployed;
  -parents smoke, drink, and/or do drugs;
  -have history of violent behavior;
  -were abused as children;

-battered now;
-children are abused, neglected;
-children in foster care;
-children 0-5 with special health and/or developmental needs.

- Comprehensive assessment, referral, services, case management, and follow-up are available to all who need them by 2003.
- See Objectives for Outcome 1 above, tailored to the groups here.

Strategies/Investment Opportunities

- Any strategy above, tailored for the particular group.
- A FRC tailored for LGBT parents, teen parents, others as identified.
- A full suite of services for homeless families, including: transportation, job training, child development activities outside business hours, training in parenting skills, counseling, centralized resources, housing, and shelter-based child care.

Evaluation Indicators (numerators only)

- Drop-outs @18 who had special needs
- Any indicator above, tailored to capture access, use, outcomes, cost for the particular group

Tailored to homeless parents:

- Taxi vouchers and mobile unit availability for parents in homeless shelters increase by 75%
- Shelter-based job training in domestic violence shelters
- Shelter-based job training for parents who leave emergency shelters to increase by 50%
- Tri-county coordination among domestic violence shelters
- Within a mile of a shelter, developmentally appropriate, safe family play space
- Monthly parenting skills training at each shelter, including child care for parents in training
- Weekly consultation to shelter-based child care staff
- Centralized, comprehensive mental health services primarily for homeless children and families
- Collaborating counseling specialists for families in DV, transitional and emergency shelters
- Referral-based counseling for parents and young children throughout homeless shelter network
- Referral list of substance abuse clinics that serve homeless parents, with child care
- Legal advocacy collaboration for immigrant families
- City-wide resources materials for each shelter, multi-lingual data access
- Stipends for monthly parent-led resource meetings in shelters
- Centralized referrals and resource coordination within shelter network
- 24-hour hotline
- Child care: at each shelter; nights; post-shelter

STRATEGIC OUTCOME XII

Disparities among newborns and children 0-5 by race/ethnicity are explicitly addressed and decreased.

Target Population

Children 0-5 and families needing enhanced services

Short-Term Objectives

- Disparities in perinatal mortality declines by 50% by 2003.
- Disparities in birth weight among newborns by race/ethnicity decline by 50% by 2003.
- Disparities in addictive substance exposure among newborns by race/ethnicity decline by 50% by 2003.
- Disparities in infant mortality by race/ethnicity decline by 50% by 2003.
- Disparities in immunization by race/ethnicity by first birthday decline by 50% by 2003.
- Disparities in lead levels by race/ethnicity decline by X% by 200x.
- Disparities in developmental status by race/ethnicity decline by X% by 200x.
- Strategic Outcomes and Objectives for 1 and 2 above tailored to reduce disparities by race/ethnicity

Strategies/Investment Opportunities

- Improve prenatal nutrition.
- Increase use of WIC.
- Increase linkages among WIC and other pregnancy and parental support programs.
- Improve WIC to reflect realities of homelessness and poverty (size; refrigeration; heating; shelter
  policies).
- Study and relieve access barriers to pre-conceptual, prenatal, primary care, and developmental assessment for 0-5 and their parents.
- Study and publicize relationships among race/ethnicity and health status of 0-5 and their parents in SF.
- Study and publicize relationships between sexually-transmitted disease and birth outcomes by race/ethnicity.
- Advocate for income enhancement policies (taxes, wages, other).

Evaluation Indicators (numerators only)

- WIC outreach
- WIC linkages
- Participation in WIC
- WIC response to use issues
- Nutritional status of pregnant and nursing mothers
- Enrollment in MediCal, Healthy Families, AIM and use of pre-conceptual, prenatal, pediatric primary care services
- Income enhancement possibilities and policy responses
- STD statistics by race/ethnicity/gender and birth outcomes

STRATEGIC OUTCOME XIII

Children 0-5 with special health care needs reach their full potential

Target Population

Children 0-5 and families needing enhanced services

Short-Term Objectives

- Families access multi-disciplinary early intervention assessment and services in natural settings

with flexible payment system and parents are members of the team.
- Families access information, education and support
- Medical home provides choice of provider and follows AAP guidelines.
- Periodic whole child assessments.
- Families access recreation and child care programs as integral team members.
- Systems are coordinated and collaborative.

Strategies/Investment Opportunities

- Surrogate parents for 0-5 in foster care.
- Interagency collaboration
- Coordinated "child find" activities.
- Multi-agency teams
- Agencies include families in design, implementation and evaluation of programs.
- Trained parent mentors in hospitals and in the community.
- One-stop shop.
- Hospitals as a center for information.
- Incentives to physicians for special health care needs care.
- Everything - providers, information, support - culturally and linguistically appropriate.
- FRCs trained in special health care needs.
- Families trained for self-advocacy.
- Training for providers in early intervention that includes homes as training sites.
- Training for families and providers on legal requirements, confidentiality, partnerships, access to records.
- Increase access to legal advocacy for children with special health care needs and their families.

Evaluation Indicators (numerators only)

- Drop-outs involved with early intervention programs
- Youth in Juvenile Hall involved with early intervention programs
- School history of children involved with early intervention programs: scores; completion
- Adherence to laws relating to early intervention, special education, etc.
- Patient satisfaction surveys yearly
- Child find activities
- Tracking parent participation by level and agency
- Protocols facilitating parental participation
- Children identified with special health care needs by age
- Providers caring for children with special health care needs
- Existence of one-stop shop
- Providers with demographics resembling those served
- Hospitals and home visiting programs with information that prompts questions and actions
- Parent training opportunities

STRATEGIC OUTCOME XIV

San Francisco neighborhoods show initial signs of community efficacy.

Target Population

Effective communities

Short-Term Objectives

- Parks and open space keep pace with population, residential mobility, and best practices for children 0-5 and their families, including those needing enhanced services.
- All SF neighborhoods include sources of healthy foods by 2005.

Strategies/Investment Opportunities

- No alcohol and tobacco ads in residential neighborhoods.
- Lowered concentration of fast food outlets in residential neighborhoods.
- Neighboring families organized for mutual support.
- Civic participation opportunities, especially for teens and busy parents.
- Prevalence and use of firearms are addressed by trade-in, registration, other programs.
- Advocacy for firearm controls.
- Health and community agencies link with law enforcement for early and appropriate intervention to protect children 0-5.

Evaluation Indicators (numerators only)

- Farmers' markets by neighborhood
- Supermarket inventories of "healthy foods"
- Alcohol and tobacco outlets
- Fast food outlets
- Merchant organizations and activities
- Parent organizations and activities
- Illegal drug dealing
- Neighborhood watch programs
- Firearm use

STRATEGIC OUTCOMES XV AND XVI

Services provided prenatally and to children 0-5 and their families are integrated into a consumer-oriented and easily accessible system.

SFCFC investments can be described and evaluated based on reliable and timely data and methods.

Target Population

Systems for child health, child development, and family support

Short-Term Objectives

- Planning for computerized linkages among government and private agencies begins by 2001.
- Planning for quality of care indicators, reporting, assessment and support for needed changes begins by 2001.
- Funding for strengthening of agency management, public and private, for operations and accountability reporting, is included in rate-setting and/or grants by public and private funders by 2003.

- Centralized planning for child care, including data collection and reporting, is institutionalized by 2003.
- A standard intake form is used by all subsidized child care providers by 2003.
- A standard intake form is used by all licensed child care providers by 2005.
- Inter-agency evaluation protocols that promote standard terminology, routines, and cross-over indicators are designed by 2003.

Strategies/Investment Opportunities
- Family resource centers link to home visiting programs, child care resources.
- Planning for multi-agency linkages by multi-agency entities.
- External agencies involved in planning by and evaluation of city departments, including academic, business entities introducing new methods and standards.
- Uniform eligibility criteria for government-sponsored programs, including health and child care.
- Uniform intake procedures for government-sponsored programs, including health and child care.
- Data elements for record keeping consistent across agencies and focus areas.
- Data systems linked across agencies and focus areas.
- Planning mechanism for child care is established by the stakeholders and funded by Department of Education and related agencies.
- Model intake forms are developed and tested.

STRATEGIC OUTCOME XVII
The child care sector has an adequate, stable, well-trained work force to promote high quality of care.

Target Population
Systems for child health, child development, and family support

Short-Term Objectives
- Attrition declines by 50% by 2003.
- All child care providers receive a living wage by 2003.
- All child care providers have access to comprehensive benefits by 2003.
- Community support for the child care sector grows steadily.
- Technical assistance for business and legal matters is available to all by 2003.

Strategies/Investment Opportunities
- Advocacy at state level for payment rates that reflect the cost of care in SF.
- Support for, expansion of, and monitoring of the CARES Initiative.
- Support for, expansion of, and monitoring of child care provider benefits program in DCYF.
- Advocacy for other mechanisms to support the child care workforce.

Evaluation Indicators (numerators only)
- Attrition by type of provider
- Turnover by type of provider

STRATEGIC OUTCOME XVIII

Child care workers have access to high quality training, conveniently located, in multiple languages.

Target Population

Systems for child health, child development, and family support

Short-Term Objectives

- All appropriate child care training opportunities are credit-bearing by 2001.
- Child care workers have attended at least two credit-bearing classes in early childhood development by 2003.
- Credit-bearing classes include diversity training reflecting SF's diverse parent and caregiver population by 2003.
- 50% of exempt providers receiving subsidies attend a child development training series annually by 2003.

Strategies/Investment Opportunities

- Investment in high quality training for all providers in multiple languages, accessible sites and in day and evening classes.
- New models of training that include multi-lingual modules.
- Training for exempt providers that reflects their needs and offers incentives to participate.
- Education institutions create credit-bearing classes in multiple languages.
- Centralized and coordinated professional development opportunities.
- Outreach and information for providers concerning educational opportunities.
- Incentives and rewards to encourage initial and continuing education, including transportation-substitutes, and child care.
- Expand assistance with legal and best practice issues.
- Diversity training for all child care providers.

STRATEGIC OUTCOME XIX

All child care programs offer services to support children with special needs and families with acute social problems

Target Population

Systems for child health, child development, and family support

Short-Term Objectives

- Expand funding and access to program and mental health consultation to 100% of child care programs by 2003.
- Increase child care capacity for children with special needs by 100% through existing collaborative programs.

Strategies/Investment Opportunities

- DPH contracts continue and expand funding for program/mental health funding.
- Outreach to family child care providers to use consultation services.
- Support for and participation of parents in any programs for children with special needs.
- Assistance to providers who make referrals for services.
- Respite care for families in crisis.

Evaluation Indicators (numerators only)
See indicators for Strategic Outcome 13 above

STRATEGIC OUTCOME XX

All child care programs meet high quality standards, including operation in safe and healthy environments for children.

Target Population
Systems for child health, child development, and family support

Short-Term Objectives
- The child care community adopts measurable, quality of care standards, including indicators and reporting mechanisms, by 2003.
- Technical assistance to introduce and meet quality standards is available within one year of their adoption.
- 50% of exempt providers receiving subsidies attend a child development training program annually by 2003.
- Increase licensing visits from state licensing authority to two annually by 2002.
- Identify and correct environmental toxins and hazards in 75% of child care programs by 2003.
- p100% of child care programs have access to visiting public health nurses by 2003.

Strategies/Investment Opportunities
- Funders and payers adhere to quality standards.
- Incentives and supports to adhere to quality standards.
- Education for parents concerning need for and content of quality standards.
- Child care facilities are secure from entry by strangers.
- Mental health consultation throughout child care settings.

Evaluation Indicators (numerators only)
Policies of funders and payers concerning adherence to standards
- Parents' choice of providers in relation to providers' conformance to quality standards
- License inspections increase from one every three years

SAN FRANCISCO CHILDREN AND FAMILIES COMMISSION
1390 Market Street, Suite 900
San Francisco, CA 94102
415-934-4854
E-mail sfcfc@dcyf.org
Website: www.sfkids.org